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COMMUNITY HOME HEALTH SERVICES ACT OF 1981

HEARING BEFORE THE COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE NINETY-SEVENTH CONGRESS

FIRST SESSION

ON

S. 234

TO AMEND THE PUBLIC HEALTH SERVICE ACT TO ENCOURAGE THE ESTABLISHMENT OF HOME HEALTH PROGRAMS AND TO AMEND THE SOCIAL SECURITY ACT TO PROVIDE EXPANDED COVERAGE OF HOME HEALTH SERVICES UNDER THE MEDICARE AND MEDICAID PROGRAMS

NOVEMBER 10, 1981

PART 2



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COMMUNITY HOME HEALTH SERVICES ACT OF 1981

TUESDAY, NOVEMBER 10, 1981

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, D.C.

The committee met, pursuant to notice, at 9:30 a.m., in room 4232, Dirksen Senate Office Building, Senator Orrin G. Hatch (chairman of the committee) presiding.

Present: Senators Hatch, Quayle, Nickles, Randolph, and Metzenbaum.

Also present: Senator Jepsen, Senator Levin, and Congressman Pepper.

OPENING STATEMENT OF SENATOR HATCH

The CHAIRMAN. The hearing will come to order.

I am especially happy to welcome everyone here this morning. Today's hearing on S. 234 is the homestretch in a legislative process which began last March 4, a campaign to consummate our common cause: the promotion and extension of home health care services.

During our preliminary hearing in this committee last spring, I said that all of my congressional colleagues support home health care, but that not all of them know what it is. I am delighted to report that this is less so in Congress today than it was then, that all of us sharing a commitment to home health care are winning the war to educate the uninitiated.

Those who first testified in March and the distinguished witnesses with us here today for today's capstone session assure by the hearing record to be produced that these lessons will not be forgotten. They must not be forgotten.

In the past 25 years the number of Americans over 65 has grown as fast as the population as a whole. Today, more than 25 million people are over 65, 11 percent of our population. Of these, the numbers of Americans in the most rapidly growing age group of all, citizens who are 85 and over, has tripled. Less than 25 years from today, Americans 65 years and older will have grown faster than our total population, increasing by another 28 percent. All of this adds up to 32 million Americans who will be over 65 at the beginning of the next century.

This is why we acclaim the achievements of medical science and hail the successful extension of the average age of life expectancy. However, in doing so, we must also bemoan the inadequacy of past

and prevailing Federal policies which too often treat senior citizens as if they were adult dependents who have never worked.

This is not the fault of any one political party or of one Congress or administration. Nor is it the deliberate handiwork of any special interest with less than a fully wholesome purpose, public or private. It is the stepchild of insensitivity. It is the lukewarm disregard of the basic rights of our elderly citizens, rights which when threatened cause not only one group to suffer but afflicts us all.

We live in a country the culture and tradition of which favor caring for elderly people at home. Yet for young couples in particular, the Federal Tax Code as presently written discourages taking in an ailing relative or other lonely family member or friend to become part of the nuclear family.

Past Congresses have awarded Federal tax credits for building windmills, erecting solar roofs, and other more exotic kinds of energy-related projects. They have awarded Tax Code deductions for improving backyards and for painting houses or apartments. There is no such economic encouragement, however, to practice home health care for senior family members.

If a family renovates a backroom or attic, adds on additional space to their living quarters to accommodate an older family member, or in some other way modifies their home surrounding for an elderly relative, there is no tax credit to help offset the cost. This becomes an especially heavy burden for many young couples with children upon whom the responsibility of caring for an elderly family member usually falls.

In contrast, Federal programs will meet the costs of institutional care in a nursing home. In three out of four cases, these senior family members are forced to enter nursing homes instead of staying with their family. The Federal Government today pays two-thirds of our country's total nursing home bill. It spends more than 9 percent of the \$5 billion spent annually on the elderly through medicaid for nursing home institutionalization. The Federal Government spends under 1 percent for home health care services.

The General Accounting Office, its senior program analysts here as witnesses this morning, and other equally respected aggregate and survey research organizations reveal in their studies' conclusions a growing number of elderly and infirm citizens who are not sick enough to be in a hospital but who are too vigorous to be confined to a nursing home.

Roughly 25 percent of our citizens now in nursing homes do not have to be there. They could get more compassionate, loving, and less costly care at home. They could get more compassionate, loving, and less costly experiences in family relationships at home.

The impetus behind the Community Home Health Services Act, S. 234, is to make this option a reality. It is to recognize the important social commitment every citizen has as a member of the American community, a commitment to assure that the elderly and the infirm who want and need assistance will be able to get it.

It recognizes that the quality of life in America is largely measured by the care and attention we give those of us who have passed the age threshold all of us must eventually pass. It is why home health care is a concept, a program, and a standard around which all of us can rally.

Every hearing of every committee of both Houses of Congress meets for some legislative purpose. I hope today's session will signify more. I hope that today's legislative forum will become a prelude to action. On behalf of the 13 cosponsors of the Community Home Health Services Act, I promise to do everything I can to see that it does.

We are particularly happy today to have with us our good friend, Senator Nickles, from Oklahoma and our good friend, Congressman Claude Pepper, who sat in this body before, who is a symbol to all aged people throughout this country of a vigorous life, one who has never ceased to work hard for the elderly, and one who is an example to many of us who may be slightly younger in age but hardly able to keep up with him in all other ways.

With Senator Nickles' permission, I would like to turn to Congressman Pepper.

STATEMENT OF HON. CLAUDE PEPPER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. PEPPER. Senator, I thank you in the warmest way for your kind invitation to be here with you this morning and to join in the exhilaration that we all have of having this greatest lady, the queen of the world's stage and screen, come here today to add her own great words to the testimony you will hear.

I think the elderly people are really the VIP's of the country. We who are here in Washington and hold some official position are often called VIP's and given preferred status in one way or another. The people who have lived longest in this country, who have done the most for it generally, who have been the mothers and fathers of the dominant generation, who have fought for the Nation in war and borne its burdens in peace, people who have held up the standard of religion and ethics and morality for the Nation are the people who are the elderly people of this country today. I think they are entitled to special recognition.

I might perhaps command the authority of the Fifth Commandment which says: "Honor thy father and mother." A lot of people forget that. They were talking about the one test that was singled out for special recognition and duty for the elderly people.

There is further wording of that Fifth Commandment that a lot of people forget. It continues: "That thy days may be long upon the land which the Lord, thy God, giveth thee." It spoke of a reward, it seems to me, for those who carried out the Biblical admonition of honoring the elderly of the land.

This provision that you are concerned with here today of home care for the elderly is one of the most important contributions I think we can make. They are entitled to it since they have five times as many health demands as younger people. They are entitled to special consideration for their health care. How could they be more happily treated than in their own homes and familiar surroundings there?

I am delighted that today you are giving emphasis to this subject that is so critical and important. I am honored to have the privilege of being with you. I commend you and your committee in the warmest way for what you are doing for the elderly of America. They deserve it, but they are grateful for your consideration.

Thank you very much.

The CHAIRMAN. Thank you so much for your gracious words. Senator Nickles?

OPENING STATEMENT OF SENATOR NICKLES

Senator NICKLES. Senator Hatch, I would just like to compliment you for bringing this issue to the forefront, which is what you are doing with this bill. I think you should be complimented for that.

I would also like to welcome our distinguished witnesses today, particularly Miss Helen Hayes. It is a pleasure to have you before this committee. We are honored by your presence. I look forward to your statements on this legislation.

I think the legislation we are talking about today as proposed by Senator Hatch is very important to foster our Nation's home health care services. For a little over a decade, such services have provided capable and willing families with the opportunity to keep their loved ones at home instead of sending them to nursing homes.

Especially in my home State of Oklahoma, where the majority of health care is administered through the medicare/medicaid program entitled nonservices technical program, such an initiative has proven both beneficial and cost effective.

No one in this room would question the importance of allowing capable senior citizens to remain in their home environment whenever possible. What we must question, however, is what the best approach is to further this goal. Does this legislation effectively address current home health care problems, and what kinds of costs are feasible to a Federal Government already strapped with current medicare/medicaid costs?

I look forward to the panel's thoughtfulness and input in answering some of these questions and in giving us further insight on the best direction to go. Again, Mr. Chairman, I wish to compliment you and our witnesses. We look forward to a very interesting and informative morning.

The CHAIRMAN. Thank you so much, Senator Nickles.

We will now turn to Senator Randolph, who has been an inspiration to all of us, especially to me. He has kind of brought me up in the Senate. I personally have great and deep admiration for him.

OPENING STATEMENT OF SENATOR RANDOLPH

Senator RANDOLPH. Thank you very much, Mr. Chairman.

I know our good colleague now from the House of Representatives, Representative Claude Pepper, who served with honor in the Senate, I feel very comfortable with all of you who are young. We want you to know that today.

It is not wrong for the record to indicate that we have worked together for a long while. I know that you are about 81 years of age. Am I right?

Mr. PEPPER. Eighty-one years young.

Senator RANDOLPH. That is right, 81 years young.

Claude is very active and productive as a Member of the Congress.

I am almost 80, just about 4 months from that wonderful date.

However, we come today to work with the members of this committee and the Members of the Congress in reference to S. 234, the Community Home Health Services Act. I would like to say to you, Mr. Chairman, that it is not a cursory comment when I thank you for your initiative in this matter.

Only recently in West Virginia I had the opportunity on a certain happy day to hand out 70 certificates to those men and women who, in their way, are doing something for home health service. I speak of the program of elderly volunteers. They are not paid money, but they are volunteers under a program known as Senior Companions.

They go into the homes of the men and women of their own ages, who have problems in looking after themselves in such matters as the ordering of their medicines, or preparing their food. About 80 percent of all those who are helped by the volunteer companion—that is what this individual is called—are living in their own homes.

That is what we are talking about here. We are not talking about institutional care as worthy as it may be and as helpful as it may be. Is my understanding correct?

The CHAIRMAN. Yes.

Senator RANDOLPH. I am not an advocate that must come out on a podium, but we need to try in every way possible—it is possible so often when we think it is not—to keep the home as the entity where men and women live, have their being, and are really productive in the areas in which they live. We have gotten away from that by many reasons which are understandable in this mobile society, this industrial, electronic, and computer world.

However, this legislation provides a challenge. I am happy to join as a cosponsor because we are not going back to something that is impractical.

You will recall that in the 94th Congress the Members of the Senate and House enacted Public Law 94-63. That was to increase and to accentuate the alternatives to institutional care. That is exactly what we were trying to do then. We were thinking about this in the 94th Congress. We hoped to provide sufficient grants to fund home health agency services in the States.

Unfortunately, the appropriations for these grants were in too small amounts. The idea was sound, but, if we cannot put it into practice, we can never do the job. There was not enough money really to do the job that we had to do.

S. 234, which you have introduced with others, is not only timely. Being timely, is not enough. Many things are timely. I offered a constitutional amendment in 1942 for 18-, 19-, and 20-year-olds to be given the right and responsibility to vote. It was just as timely then as it was in 1972, 30 years later when it happened.

We have to build in the history and get people to understand what we are trying to do. In this legislation, the need is there for home care and for the alternatives that we know exist in direct proportion to the increasing population of elderly men and women in this Nation.

Congress is cognizant of this. To a degree, corporations and private companies have also recognized this need. Already we have struck down the automatic retirement age of 65 within the Federal

Government. It should never have been there. As long as that individual, man or woman, is doing the job efficiently with a desire for service, if that individual is in good health and wants to remain on the job, what is the reason, for taking them away from the job to make way for someone younger? I do not understand that philosophy.

When we think of the number of those who are now 65 years and older, the increase is astounding. Naturally I like to talk about West Virginia. There are only eight States in the Nation having a higher percentage of people over 65 than West Virginia, but we are not in the Sunbelt in the Southwest or the South. We are just hardy people in the hills where it gets cold in the winter.

However, for the record, in West Virginia we have 330,522 men and women who are over the age of 60, and 237,868 of this number are over 65 years of age. That is 16 percent of our total population in the State of West Virginia.

I was just talking to a very fine lady within the week who has just celebrated her 100th birthday. She received a new fishing rod. I asked, "What in the world are you going to do with that?" She said, "Oh, I fish in the Potomac and the Shenandoah, and the rural mail carrier, he knows that. So he gave me new fishing rod." You see, that the ages of 60 or 65 do not mean anything to her because she still is active, at 100 years of age.

In 1980, the cost of health care in this country reached the sum of \$247 billion, an amount equal to 9.4 percent of our gross national product. These costs continue to accelerate while our overall economy certainly has shown a sluggish growth factor. We are all aware of this situation.

Under medicare and medicaid, benefits paid in 1980 totalled \$60.6 billion, including \$35 billion for hospital care alone, representing a Federal outlay of 28 percent for all personal health care costs in this country in the year 1980. Nursing home care during the same year cost us \$21 billion. That is an increase of 16.6 percent over 1979.

As we go into this matter, I think we can come to the place where we can understand that the current orientation of medicare/medicaid spending is for hospital reimbursement. This policy has caused hospital care use to jump from 39 percent in 1965 to 54 percent at the present time.

The total number of persons aged 65 is projected to reach 32 million in the United States by the year 2,000. Therefore, if we are hoping, as we are, to be ready for their health care needs to be met in the years ahead, we need to begin now to build a home health care delivery system.

Therefore, as I said, this legislation is based on sound reasoning and the premise that I have explained at least briefly. When we consider the billions of dollars spent last year on hospital and nursing home care for the elderly and others who are homebound due to physical impairment, it is only reasonable to consider home care for those individuals as cost effective not just in dollars and cents but in terms of eliminating the associated mental and emotional health care costs for these same individuals who live with years of stress from worry over becoming financial burdens to their family. As a result of growing old and the fear of being placed in

an institution often far away from their homes and families, you have really begun to cut their lives down, cut them down to a few short months in some instances.

The men and women of the generation of which I am a part, recall the time when those who were elderly members of the family, parents and other dependents, lived with grown children. We still have that in West Virginia.

By the way, I am the author of the Grandparents' Day legislation which was enacted in 1980. Someone wrote me a very sassy letter asking why I was interested in grandparents. I said that I was a grandparent. That ought to be one good reason.

I introduced the National Grandparents' Day in the 95th and 96th Congress. It designates the first Sunday in September after Labor Day as Grandparents Day. Last year, in September of 1980, we had its first observance.

Grandparents in my generation knew their grandchildren. They loved their grandchildren. They helped to rear their grandchildren. They knew elderly aunts and uncles. They knew their nieces and nephews as a part of the home community where they were born.

Progress has brought about social changes, desirable, inevitable, necessary as we are a mobile society. However, with desirable and noble advances of a good and great people, as we certainly can say we are, there came the undesirable changes, the chief one being the fragmentation of family life in the United States.

I do not know whether that is a favored topic of yours at any time, but I wish it was the favorite topic of all the Members of the Senate and the House of Representatives.

By providing assistance to permit the elderly and disabled to remain close to their loved ones in the surroundings they understand, either in their own homes or with others who are members of the family, we have given them hope, which is a good feeling, not the guilt they often associate with becoming a financial burden within a very large bureaucratic system.

This step that we take toward restoring family unity is lacking in too great a degree in our social structure today. This bill takes us in the right direction. It increases the numbers of home health agencies, the training of professional home care providers, the expansion of medicare and medicaid coverage in these services, and provides tax incentives for families caring for dependent relatives in their homes.

We spend weeks and months in the Senate on bills. I not only recommend the enactment of this bill, but why do we not take a bill like this and show that we do not need to take 6 months or a year to pass it? Why do we not move it from this committee, move it to the Senate? I think in so doing we will be proving ourselves at least for once during these times in moving ahead in what I call a very practical way without a lot of window dressing.

Therefore, I will work with you in the final development of this legislation and share with you and others our concern for the unique problems associated with the implementation of new home health care initiatives. We know in West Virginia what this legislation could and would mean. I am sure it is so in many other areas of the country.

Having talked too long, usually I apologize, but not this morning. Thank you very much.

The CHAIRMAN. Thank you. You have made a lot of very good points, Senator Randolph.

We are happy to have Senator Metzenbaum from Ohio with us today.

OPENING STATEMENT OF SENATOR METZENBAUM

Senator METZENBAUM. Mr. Chairman, I commend you for your leadership in introducing this legislation.

I do not yield to many other Members of the Senate my ability to filibuster and once in awhile even make an adequate speech, but today I think neither are called for. This is a special occasion. These people did not come to hear me. We came because we have the privilege of being part of a select audience to hear the first lady of the theater. I yield to the first lady of the theater.

The CHAIRMAN. Thank you so much, Senator Metzenbaum.

At this point, prepared statements by Senators Hawkins, Quayle, and Tsongas will be made a part of the record.

[The prepared statements referred to follow:]

PREPARED STATEMENT OF SENATOR HAWKINS

Senator HAWKINS. As Senator Hatch has pointed out, continued growth in the elderly population threatens to outpace available health care facilities and could create shortages unless changes are made now. This increase in the elderly population will reach its apex when the children of the postwar baby boom reach retirement age; 28 million people will reach age 65 in the decade of 2010 to 2020, as compared with 15.5 million in the last decade. I think it is important to note that while this rapid increase of the number of elderly will place a strains on traditional long-term health facilities, such as hospitalization and nursing homes, only about 3.4 percent of those over 65 years of age will require institutionalized care. Therefore, we must pay equal attention to developing and expanding alternative forms of health care to insure that the elderly have a variety of options from which to choose.

We in Florida are well aware of the increase in the elderly population. We now have a higher proportion of elderly citizens than any other State. One of the main reasons that the elderly are attracted to Florida, aside from the beauty of the State and its climate, is that Florida offers a wide range of alternative health care services to the elderly.

We have 327 licensed nursing homes, 143 home health care agencies, 726 congregate living facilities, 21 adult day care facilities, 803 adult foster homes, and a wide range of services to the elderly that allows them to choose the level of health care that best suits them.

Home health care has undergone rapid expansion in Florida. In 1972, Florida had 29 home health care agencies, compared with the 143 licensed home health care agencies that exist today. Federal reimbursement for home health services in Florida has jumped from \$1.4 million in 1972 to \$43 million in 1978. However, the rapid expansion of home health care has not been without its growing

pains. Florida home health care agencies have an unenviable record of criminal charges, fraud, and abuse and an unreasonably high denial rate for reimbursement by the Health Care Financing Administration. This disturbs me because it casts a shadow over the remainder of excellent home health agencies which offer skilled, compassionate care to the elderly. I am pleased that Senator Hatch has considered the need to amend S. 234 to strengthen the protections against fraud in this program.

I look forward to hearing the testimony presented today.

PREPARED STATEMENT OF SENATOR QUAYLE

Senator QUAYLE. I wish to thank the chairman for holding these second hearings on the proposed Community Home Health Services Act and the important issue of home health care services.

This is a vitally important issue. In the year 1900, 1 in every 25 Americans was age 65 or older. In the year 2000, up to 1-in-8 individuals will be 65 or older. The number of homebound will be nearly 2 million persons. What we are talking about is an explosion in the increase of numbers of Americans 65 and older.

Nursing homes cannot, and should not, meet the needs of all these people. Currently these are nearly 37,000 elderly being cared for in nursing home facilities in the State of Indiana, but just over 12,000 are receiving home health care services. Lack of facilities, barriers to services in the home, and skyrocketing health care costs all work against those who seek proper medical care in their homes. A report by the Comptroller General to the Congress reports of increasing barriers to receiving quality institutional services, and of ever increasing costs of Medicaid as the chief supporter of nursing home costs. Medicaid expenditures on nursing home costs will be up to \$8.2 billion this past year.

The problem of nursing home expansion aside, not all elderly citizens want or ought to be institutionalized. Indiana, for example, has a long history of home health services, dating back to 1911 when the Visiting Nurses Service was established there. Still, 500 nursing homes in Indiana try to meet the needs of nearly 37,000 elderly being served there.

Many elderly prefer to be at home, not only for the comfort of their accustomed surroundings, but because of the dramatically lower costs. The cost for a visiting nurse in Indiana ranges from \$240 to \$300 a month—for three visits a week. This compares with a cost of \$1,050 a month and up for care in a skilled nursing home. Residential care in a nursing home averages over \$480 a month, and a stay of the same time in an Indiana hospital at \$234 a day totals \$7,019 a month.

I believe it is clear that home health care can provide an efficient and effective way to serve many of the elderly's health care needs, as well as the preferred way. I hope that our hearings today can explore these cost and efficiency aspects, as well as the needs and preferences of our older Americans.

PREPARED STATEMENT OF SENATOR TSONGAS

Senator TSONGAS. It is particularly timely that we are holding the final phase of hearings on the Community Health Services Act

of 1981 this week. On Friday, the Senate is scheduled to bring consideration of the health and human services appropriations bill. There are funding levels in that bill for several health programs that fall short of the appropriations needed to guarantee quality health services for all Americans. Keeping that in mind, we must be cautious on how we spend our health care dollars. And, we must seek cost-effective measures that insure a continuation of quality health care services for all Americans.

The Community Health Services Act of 1981 addresses a veritable need among the Nation's elderly population; a need that will expand as the demographics of our Nation continue to change. It is time to prepare for a future which will see an increase of about 25 percent of American citizens over the age of 65 and 50 percent of people over the age of 75 by the year 2000.

The current waiting lists for admissions to nursing homes are a clear indication that we are not prepared to meet the needs of the growing elderly population. The fact that many of our citizens are forced into institutions when they would like to remain in their homes demonstrates that we are not prepared for the future.

I think it is important to emphasize that nursing homes and institutionalized care are a vital part of the network of services that are provided for the elderly. There will always be a need for this kind of care and elderly person in need for nursing home care or institutionalization should be denied that service.

There are, however, an increasing number of elderly citizens who do not choose to go into nursing homes. They are forced to go because they have no other alternatives. Legislation such as this offers promising alternatives to the options of nursing home care or medical and social isolation.

When this bill is finally reported out of committee and hopefully considered by the full Senate, it is our hope that we can say to all aged, homebound and disabled citizens that you can remain at home and receive adequate services.

I am moved by the interest that so many people have taken in this issue and in this legislation. I believe that these hearings can result in humane and comprehensive home health care legislation.

The CHAIRMAN. Last week, by unanimous vote, the Senate passed Senate Joint Resolution 113, legislation I introduced proclaiming this week of November 8 National Home Health Week. This being National Home Health Week, I cannot think of any nicer way to celebrate it or to call attention to the important purpose of today's hearing than to call upon our first witness.

To say that she is incomparable is to understate the matter. She has long been an effective and outspoken advocate for the elderly. As a member of the Board of Directors of the National Council on Aging and Chairwoman of the Council's National Center on Arts and the Aging, she participated in this year's White House Conference on Aging. I am told that someone remarked that they knew she was not an elected official because she attended all of the sessions.

Born in Washington, D.C., on October 10, 1900, she made her Broadway debut at age 9. During her distinguished stage career, she has been called the first lady of the American theater, as

Senator Metzenbaum has reminded us, for the reason that she really is the first lady of American theater.

She is the only actress to have won two Academy Awards, both for best actress in 1931 and best supporting actress in 1971. Of her countless television screen performances, two which are relevant in this morning's hearing are the "Snoop Sisters" and "Miles To Go Before We Sleep," a television documentary on mandatory retirement for which she won the distinguished Peabody Award.

Our first witness has performed in more than 30 countries in Europe, the Middle East, South America, and Asia during tours for the U.S. State Department, and has been decorated by several foreign governments. She has been awarded medals of honor by many U.S. cities and States, receiving honorary degrees from more than 40 American colleges and universities.

She was chosen 1 of 8 women of the year in 1973, and was also voted 1 of the 10 American women of the century by the "Ladies Home Journal." She is the author of "Gift of Joy," "On Reflection," and "Twice Over Lightly."

If there is anything worth doing that has not already been done, I know that she will probably do so after this hearing. It is a pleasure and an honor to introduce to this hearing one of the most distinguished Americans ever to testify before the Congress, Miss Helen Hayes. We are so delighted to have you with us.

STATEMENT OF MISS HELEN HAYES

Miss HAYES. Thank you, Senator. Thank you for that extraordinary introduction. I do not recognize that woman very much.

The CHAIRMAN. We all do.

Miss HAYES. I am afraid I am going to be a comedown after that introduction.

I was fascinated by what all of you legislators were saying. I especially want to thank Senator Randolph for his efforts to bring grandparents back. It is the memory of my grandmother that makes me yearn to see the elderly come back into the family picture.

A grandmother is a very important thing in life when you are growing up. For one thing, there is a lap, or there used to be a lap. Skirts are too short to give you laps anymore. However, a lap was a good thing to fall into when life overwhelmed a 6-year-old. Along with that lap there were comforting and wise words. There were good stories from my grandmother who was Irish of the old country. I treasure this as a very strengthening part of my growing up.

Therefore, I am not just concerned with the elderly. It is the whole business of family and the advantages that members of families have for each other.

Now I am going to stop rambling and get on to my prepared statement.

Growing old is a slow and personal process that affects each of us differently. Yet it is a terribly demanding time because it forces changes we are not ready to make. Sometimes the changes are sudden and enormous.

I remember how difficult it was for me when a doctor right here in Washington at the Providence Hospital told me that my allergy-induced asthma would not permit me to continue appearing on the

stage. He took some tests while I was over there after having a seizure that I had gotten used to having during rehearsals and sometimes during the run of a play, and he discovered that I was allergic to theater. He threatened me with a quick finish if I went back. Well, I had to go back because I had contracted to do a play and actors do not break contracts if they are real actors.

I had spent my whole life in the theater and I wanted to go on, but I could not after that engagement. I had to quit. Well, I thank God for the 10 years I have had since then. I have been healthy and able to find joy in other places.

However, I have never forgotten the shock that I felt when the doctor told me that the life I had led for 70 years had to change. This was the same shock I saw in many of the people I met while working on the public television documentary "No Place Like Home." They too had been forced to slow down and they were wondering how to manage their changed lives.

I am not a gerontologist or a geriatrician, but I am 81 years old and at least an interested observer in the aging process. My best observation is this: The changes demanded by old age are tough enough to accept. Maintaining as much independence as you can makes it easier to yield gracefully to those changes. However, this is not an insight that seems to have shaped much of our Government policy on caring for the elderly.

In Los Angeles, I spent a day with a wonderful feisty little gal named Verna Rogers, 82 years old, who checked out of nursing homes six times so she could live on her own. Last time, she fought them off with her crutch until she got out of reach.

Verna suffered from just about every disease you could imagine, but she had the courage and the will to live as independently as she could. There she was, tucked away in a funny little old flop-house down in the worst district of Los Angeles, but happy and content. Verna received little help in the single room she called home, but she went on and she realized her wish. She died in her own home.

We found other individuals who not only had Verna's independent spirit but who had the help they needed to stay at home. There was 82-year-old Sally Humason in New Britain, Conn. She had spent more than a year in what she considered to be a very good nursing home. For part of that time she needed to be there for intensive therapy.

However, there was also a period, a much too long period according to Sally, when she languished in that home, just getting up in the morning and going to bed at night. Sally needed more. To this day, she is a published writer. Most recently she had a story in *Good Housekeeping*. If you write, you need privacy and quiet and plenty of books around you. However, nobody in her nursing home understood that, and the regulations allowed Sally just one book at a time in her room.

She said to me, "I never saw anybody in all the time I was there with a book in their hands." She had no one to communicate with who talked her language and thought her world. Sally thought she would end like that.

However, a group called Triage arranged enough services to put Sally back in the rambling old house she had lived in since she was

a year old. Triage took a good look at Sally's situation and ordered a nurse, a therapist, some wheelchairs, and someone to help Sally up the stairs at night to bed.

On average, Triage found that it could provide its 1,040 clients with all the necessary services at one-third the cost of a nursing home stay. However, on December 31 of this year, Triage will lose its Federal funding, and the program's director estimates that 425 clients will be immediately institutionalized. The \$3.4 million that the Government will spend in 6 months on these 425 people alone in institutions could have funded Triage for an entire year.

I also met Caroline McCaull in Minneapolis, Minn. After years of dialysis and lengthy hospitalizations, Caroline McCaull had had enough. She came home to die in the place where she had always lived.

Practically bedridden, Mrs. McCaull needed someone who would care for her. Her daughter, Mary, decided to share her mother's last days at home. Mary left work to care for her mother. She needed to learn some basic nursing skills. She needed some income to keep the house going. She needed someone to tell her that her pain, guilt, and anger were feelings that were a natural part of watching her mother die.

She got all this from the Ebenezer Society, a church affiliated group which teaches people how to care at home for family members who are sick and old. It did not cost much money to teach Mary Baker what she needed to know because it was a labor of love, but it was worth a fortune to Caroline McCaull to be in her own bed in the home she had owned since 1945.

Mrs. McCaull was looking forward to our broadcast, but she died last month. Her daughter told us how grateful she was to have been a part of the Ebenezer program and to help spread the word about the importance of helping families keep loved ones at home.

In California, Minnesota, Kentucky, and Connecticut, where I traveled with the WNET group, I was heartened by the variety of alternative programs that were keeping the elderly out of institutions. However, in far too many cases, the people I met had no alternative to nursing homes when they could no longer manage on their own.

I remember talking with Helen Riali. Her husband, Emil, had suffered a stroke in 1970, but Helen had kept him home for 11 years, though she got no help. Then Helen got sick and Emil went into a nursing home. He may never get out because his wife is no longer strong enough to help him in and out of bed in the morning and at night.

Helen Riali asked me one question I could not answer: "Why was there so much money to put Emil in a nursing home but nothing to help him in and out of bed in the morning?"

It seems like a small thing, until you cannot do it anymore. However, that is how things hit you. When Government policy forces restrictions even greater than those imposed by age, it just seems to me to be almost deliberately cruel.

I met Joseph Farley in a public nursing home in New York City. After 13 years in the home, the thing he missed most was taking a snack out of his own refrigerator. I heard that several times. It was the one last independent gesture they could make to go to the

refrigerator when they wanted to and eat what they wanted to out of it. It may not be much, until the small decisions are taken out of your hands and you find that your great age has reduced you to a child.

I do not attack nursing homes, believe me, because they are necessary for tens of thousands of Americans who have been overwhelmed by age and cannot care for themselves anymore. However, we found thousands of elderly Americans who were swept into nursing homes because they needed some small help that was not available at home.

These are the people I spoke to for "No Place Like Home." They are people very much like you and like me.

Thank you.

[The prepared statement of Miss Hayes follows:]

MISS HELEN HAYES'
STATEMENT BEFORE SENATOR HATCH'S COMMITTEE ON HOMECARE
November 10, 1981

Growing old is a slow and personal process that affects each of us differently. Yet it is a terribly demanding time, because it forces changes we are not always ready to make.

Sometimes the changes are sudden and enormous. I remember how difficult it was when my doctor told me my health would not permit continued appearances on the stage. I had spent my whole life in the theater and wanted to go on, but I could not.

I thank God for the ten years I have had since then. I have been healthy and able to find joy in other places.

But I've never forgotten the shock I felt when my doctor told me that the life I'd led for 70 years had to change.

This was the same shock I saw in many of the people I met while working on the public television documentary NO PLACE LIKE HOME. They too had been forced to slow down and they were wondering how to manage their changed lives.

I'm not a gerontologist or a geriatrician, but I am 81 years old, and at least an interested observer of the aging process.

And my best observation is this: the changes demanded by old age are tough enough to accept. Maintaining as much independence as you can, makes it easier to yield gracefully to those changes.

But this is not an insight that seems to have shaped much of our government policy on caring for the elderly.

In Los Angeles, I spent a day with Verna Rogers, an 82-year-old woman who checked out of nursing homes six times so she could live on her own. Verna suffered from just about every disease you could imagine. But she also had courage and the will to live as independently as she could.

Verna received little help in the single room she called home. But she went on, and realized her last wish: to die at home.

We found other individuals who not only had Verna's independent spirit, but who had the help they needed to stay at home. There was 82-year-old Sally Humason in New Britain, Connecticut. She had spent more than a year in what she considered a good nursing home. For part of that time she needed to be there for intensive therapy. But there was also a period -- a much too long period, according to Sally -- when she languished in that home, just getting up in the morning and going to bed at night. Sally needed more. To this day, she writes stories for magazines, most recently for Good Housekeeping. And if you write, you need privacy and quiet and plenty of books around you. But nobody in her nursing home understood that and regulations allowed Sally just one book at a time in her room.

Sally thought she would end like that, but a group called TRIAGE arranged enough services to put Sally back in the rambling, old house she had lived in since she was a year old. TRIAGE took a good look at Sally's situation and ordered a nurse, a therapist, some wheelchairs,

and someone to help Sally up the stairs at night. On average, TRIAGE found that it could provide its 1,040 clients with all the necessary services at one-third the cost of a nursing home stay. But on December 31st of this year, TRIAGE will lose its federal funding and the program's director estimates that 425 clients will be immediately institutionalized. The 3.4 million dollars that the government will spend in 6 months on these 425 people alone, could have funded TRIAGE for an entire year.

I also met Caroline McCaull in Minneapolis, Minnesota. After years of dialysis and lengthy hospitalizations, Caroline McCaull had had enough. She came home to die in the place she had always lived.

Practically bed-ridden, Mrs. McCaull needed someone who would care for her. Her daughter, Mary, decided to share her mother's last days at home. So Mary left work to care for her mother. She needed to learn some basic nursing skills, she needed some income to keep the house going, and she needed someone to tell her that her pain and guilt and anger were feelings that were a natural part of watching her mother die.

She got all this from the Ebenezer Society, a church affiliated group which teaches people how to care at home for family members who are sick and old. It didn't cost much money to teach Mary Baker what she needed to know, because it was a labor of love. But it was worth a fortune to Caroline McCaull to be in her own bed in the home she's owned since 1945.

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of the Ebenezer program and to help spread the word about the importance of helping families keep loved ones at home.

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I don't attack nursing homes, because they are necessary for tens of thousands of Americans who have been overwhelmed by age and can't care for themselves anymore.

But we found thousands of elderly Americans who were swept into nursing homes because they needed some small help that wasn't available at home.

These are the people I spoke to for NO PLACE LIKE HOME. They are people very much like you and me.

The CHAIRMAN. Thank you, Miss Hayes.

Senator RANDOLPH. I would like to applaud. May I?

The CHAIRMAN. I think that is most appropriate. [Applause.]

This courtly southern gentleman just hit the right note here on that.

We have Senator Levin with us here this morning. He would like to make a few comments before we ask some questions.

**STATEMENT OF HON. CARL LEVIN, A U.S. SENATOR FROM THE
STATE OF MICHIGAN**

Senator LEVIN. Thank you very much, Senator Hatch.

First of all, I want to express my gratitude to you for inviting me to sit with this committee this morning. This is a very important day for this country when someone like Helen Hayes comes before this committee and testifies in favor of a bill which will mean so much to so many people.

You have continued a great tradition here this morning, Miss Hayes. It is another standing room only audience. You are used to that.

Miss HAYES. I did not dare look before.

Senator LEVIN. I can speak from personal experience. Like the vast majority of us, I have a mother. My mother is bedridden. My mother is lucky enough to have a devoted daughter who lives nearby and to have still sufficient resources so she can pay for the home health care that she wants. She wants to be at home. She insists on being home for all the reasons that Verna and your other friends want to be at home. There is more independence. It is part of her.

She is lucky. Many are not lucky either resourcewise or because they do not have the children or the grandchildren nearby who can make the sacrifice. There are sacrifices involved in home health care.

This bill will remove the economic disincentives to home health care. It will eliminate the incentives toward institutionalization which we should remove. It is long overdue that we remove them. No one can speak more eloquently than you can on that subject.

All I can say is I personally have gone through this. Recently, the Senate accepted an amendment which I offered which will encourage the use of welfare people to help medicaid patients to stay at home. It is a provision which makes a lot of sense because it gets people off welfare and it saves money for medicaid when we do not have to pay for institutionalization.

This bill too is a giant step forward. It is a totally positive bill. It is not antinursing home, as you point out. It is prohome health care, propeople, proelderly, pro their children pro their grandchildren because it will help keep them together when they want to be together and when they most need to be together.

Senator Hatch and members of this committee, you are due nothing but congratulations for what you are doing.

Miss Hayes, you continue in your great tradition. You brought so much joy on the stage to so many millions of people. You are here an angel of mercy again. I think, if anything, you are exceeding the gift which you gave to the world so many years ago.

Thank you, Mr. Chairman.

The CHAIRMAN. Miss Hayes, we have a vote going on on the Senate floor. I hate to ask you to do this, but would you mind waiting until we get back? I do have some questions that I would like to ask you because I think you, with your particular perspective, will be very helpful to us on this bill.

We appreciate the kind comments of my colleagues this morning, and certainly Senator Levin taking time to come over, as well as Claude Pepper. I think that has added much to our hearing.

If you will not mind waiting, we will rush over and come right back.

Miss HAYES. Fine.

[Recess taken.]

The CHAIRMAN. If we can begin again, I certainly apologize to all of our witnesses. We have another vote coming up right after the first one. I thought I might as well stay for the second vote and see if I could ask some of these questions in between.

Miss Hayes, I felt that your testimony was very moving. While you were working on the PBS documentary, I am sure you had the opportunity to speak with many people living in nursing homes of every variety. Would you share with us some of their own feelings about being institutionalized, and were there any exceptions to your own observations about long term care and institutionalization?

Miss HAYES. Most of the nursing homes we visited were of very good quality. The people I spoke with never complained about the bad care or any cruelty, nothing melodramatic. However, they did mourn their lack of independence. Over and over, everywhere we went, I heard the same refrain: I want to be independent. As I spoke of in my statement, they wanted to go that icebox and get out what they wanted when they wanted it. It was those silly, simple little things.

Sally Humason, to whom I referred when I told you about Triage, said that the nursing home she had been in was a very good one, but she missed being surrounded by what was familiar. She has a dog. You cannot have a pet in a nursing home. That is a very important thing. She missed having privacy and a degree of

control over her life, even though she spent most of her time in a wheelchair. The elderly I spoke with talked more of independence of spirit than of body.

I spoke to a couple in Pasadena, Calif., the Reimers. Mrs. Reimer had been put in a nursing home because of crippling arthritis. She and her husband thought it would be temporary. Her doctor said 3 months at the most. That 3 months turned into 3 years. The only thing preventing Mrs. Reimer from going home was that the entrance to their apartment had 37 steps and it was impossible for her to get up those steps.

She and her husband want to be together. He spends every day at the nursing home with her. Their savings are almost exhausted. Her husband told me that he had aged more in the last 3 years than in the previous 20. Again, it was a very good home, but the Reimers wanted to get on with their lives.

I spoke with an extremely articulate man in Kings Harbor Nursing Home in the Bronx, N.Y. His name was Richard Winn he said:

In nursing homes, we do lose that personal touch, the dignity of the thing, one's worth as a human being. After all, I am a human being. I am not a cipher. I am not a nameless number. I am me.

The CHAIRMAN. There seems to be a general feeling that American families no longer want to keep elderly relatives at home, that aside from the economic disincentives built into the prevailing medicare coverage arrangement there is also a social stigma, against younger family members taking care of elderly family members in need of such help.

Based on your travels and your most recent work, do you find this to be true?

Miss HAYES. No; I think that is a myth. I think people do want to keep their loved ones at home, but many circumstances and pressures make it very difficult for them to do so.

What happens when a middle aged woman has to go back to work and help pay for her children's college tuition? There is nobody there to take care of the elderly relative. Traditionally, she would be at home caring for the elderly relative, but because of the financial pressures she has to return to work.

Many of the women I spoke to who put their husbands in nursing homes only did so after many, many years of trying to keep them at home. Those were the most heartbreaking cases. It was not actually the people in the nursing homes because, believe me, they had gotten rather dull eyed and accepting. That was heartbreaking, too, but the people who had to put them in there and had to face up to what they had done felt such guilt and such misery.

One woman I talked to in Marin County, Calif., had kept her husband home for 17 years with no help. Finally, her own health began to go and she was forced to put him in a home. Many of the people I met in making this documentary were torn apart by the decision to turn to a nursing home. They simply could not manage. It was not for lack of affection, believe me. It was just circumstances.

The CHAIRMAN. During the course of your most recent work, I note that you traveled extensively through long-term care facilities in Appalachia, New York City, Minneapolis, and Los Angeles, just to name a few areas. Are there any general insights that you

would draw from this broad sample? Are there noticeable ways in which these various approaches to long-term care differed in different parts of the country?

Miss HAYES. They differ to some degree as the ethnic backgrounds of people sometimes differ in the approach to long term care. In Kentucky, for instance, there was a long tradition in that State among those Appalachians of looking about our own. That is the phrase they use. This makes home care a natural approach.

In Minneapolis, where people's heritage was northern European, congregating living seemed to be the most appealing, as in Scandinavia.

However, it is also amazing to think of similarities between places that on the surface appear to be so different. Take New York City and Hindman, Ky., deep in Appalachia. Both places have a similar approach to helping the elderly stay at home. I think this happens to have something to do with two great people who were at the head in each State of this organization.

In New York City, it was the Chelsea Village program under the supervision of Dr. Philip Brickner, who is to testify here today. He is a great man.

The CHAIRMAN. He sure is.

Miss HAYES. His teams of doctors, nurses, social workers, and home aides provide services in the homes of frail elderly people who would otherwise be in institutions.

In Appalachia, we met up with a wonderful team. Their names sound like a comedy team in vaudeville: Benny Ray Bailey and Grady Stumbo. Is that not a remarkable pair of names? They are both saints, by the way, not one bit funny.

Benny Ray Bailey is a social worker and an organizer. He is the head of this great clinic that they have started. They were boyhood friends. Grady Stumbo became a physician. They started the East Kentucky Health Services Center. They are training family members to administer much of the care the elderly require.

There are so many possibilities of adult care: congregating living, home care, et cetera. Our country is vast. However, the desire to be at home is found everywhere.

The CHAIRMAN. Some of the people you interviewed in nursing homes required 24-hour nursing home care. However, apparently quite a few did not. Could you give us some examples of elderly people who were inappropriately institutionalized and what kept them from staying at home?

Miss HAYES. I spoke before of the Reimers not having a ground floor apartment. Mr. Farley—there he is up there, bless his heart [indicating]—did not have any place to call home. That made him stay for 17 years at a hospital in New York. For Emil Riali it was not having someone help him in and out of bed.

For others, it may be not having someone to shop, cook, clean for them, or just generally take care of the household chores. The lack of someone for that requires them to be institutionalized. Many people definitely need nursing home care, but it is such a pity when something as simple as not being able to get out of bed in the morning causes you to go to a nursing home.

You know, we have lengthened life through science. We are all living longer. My grandmother lived to be 70. My mother lived to

be 74. I am 81, and here I am sitting up here making a lot of noise. We have lengthened life. We have made it possible for our people to live many more years. Now we have to make those years worth living. That is what I hope you are going to achieve.

The CHAIRMAN. One last question from me: It is by this time of course no secret to all of us in this room that we are inspired by your own commitment and active concern for our Nation's elderly. Based on your own observations, what do you think we as legislators could do to improve the quality of life for our elderly citizens?

Miss HAYES. Frankly, without expanding Government support for home care and day care and congregate living, there is very little hope that anything will change significantly. Older people deserve choices about how they will live out their days. I think the Community Home Health Services Act of 1981 is a step in the right direction. God bless you, Senator, and your whole team here.

The CHAIRMAN. Thank you so much.

We have our great young Senator from Indiana here, Senator Quayle. Do you have any questions?

Senator QUAYLE. Thank you very much, Mr. Chairman.

It is certainly a great privilege for myself and, I am sure, for others, for you to come before this committee and testify. You have been a wonderful and gracious woman and quite an inspiration to many people.

I just have one question. I believe it was Will Durant, who recently passed from our midst, said that the nucleus of civilization was the family. I just wonder if you might comment on the home health care legislation that the chairman has proposed and what kind of an impact and benefit it might have to the family unit and extending that family unit from very young life to very old.

Miss HAYES. I was just talking with Senator Randolph on that subject earlier. Family has become too fragmented, I am afraid, for anybody, not only the elderly, but, as I said to Senator Randolph, I am thinking also of the very young.

I grew up in a family where a grandmother lived with us. That grandmother was very strengthening to me and gave me one more person to love. This sounds sentimental, but I think it is sound. I do not think it is really sentimental. It just sounds that way. I believe that the more people that the young learn to love early in life the stronger they are to face everything.

I had the advantage of a grandmother who lived in the house with us to love. She was so supportive to me and so strengthening to me as a child. She was such a joy to me with her weird and wonderful stories about people waking from the dead in Ireland. Oh, they were fierce stories. I loved them.

I think that if we could make an inch toward getting the family back together and getting the older generation back in with the younger, we would be doing a good turn. Is that what you were asking?

Senator QUAYLE. Do you feel that this legislation that we are talking about might contribute to getting to the family, or at least provide an opportunity for those who want to have home health care?

Miss HAYES. Yes, I hope so.

Senator QUAYLE. So do I.

Miss HAYES. I am wishing you well.

Senator QUAYLE. Thank you very much.

The CHAIRMAN. Thank you, Senator Quayle.

I would like to draw the audience's attention to the upcoming television documentary report produced by WNET, channel 13, in New York to be aired Monday, November 16 at 9 p.m. It will be entitled "No Place Like Home." This is being aired 2 weeks before the culmination of the yearlong 1981 White House Conference on Aging. Of course Miss Hayes plays a prominent part in that.

One more time, we just want to thank you so much for taking time from your busy schedule to be with us. If I may, I would like to come down and kiss Miss Helen Hayes before we finish for today. [Applause.]

The CHAIRMAN. For the past couple of years there has been an increasing number of surveys and studies not only by the General Accounting Office but by other organizations, both private and public, all coming to different conclusions about the need, efficacy, and cost of home health care programs.

Shortly after introducing S. 234 last January, I requested the General Accounting Office to do a new survey study specifically highlighting home health care services, issues such as fraud and abuse, reimbursement, and cost effectiveness among others, and tying all of this to my own legislation, S. 234.

I am grateful to the General Accounting Office for being with us today. On our next panel, GAO senior analysts will be reporting on the results of their work. Before they do so, I want to add a personal word of thanks to the GAO team which spent so much time and worked so diligently producing what I believe is the most definitive work today on GAO's assessment of home health services.

Two members of that team, Senior Program Analyst Jim Solomon and Janet Shikles, worked especially hard and are a credit to their agency as they are to our Government as a whole. I am very happy to have both of them with us this morning.

The committee is very pleased to have Eleanor Chelimsky with us today. Ms. Chelimsky is Director of GAO's Institute for Program Evaluation. I know that Ms. Chelimsky was an economic analyst for the U.S. mission to NATO and still serves as president of the Evaluation and Research Society. So, Ms. Chelimsky, I guess it is no exaggeration to say that you are good with numbers. We are very happy to have you here. You will be spokeswoman for the whole panel. We will turn to you at this time for your testimony.

STATEMENT OF ELEANOR CHELIMSKY, DIRECTOR, INSTITUTE FOR PROGRAM EVALUATION, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY JANET SHIKLES, GROUP DIRECTOR, INSTITUTE FOR PROGRAM EVALUATION; JAMES SOLOMON, SENIOR ANALYST, INSTITUTE FOR PROGRAM EVALUATION; TOM DOWDAL, GROUP DIRECTOR, HUMAN RESOURCES DIVISION

Ms. CHELIMSKY. Thank you so much, Senator Hatch.

Good morning, Mr. Chairman and members of the committee. We are very pleased to be here today to testify on the issue of

home health care and S. 234, which is the proposed Community Home Health Services Act of 1981.

Let me begin, Mr. Chairman, by introducing the people who are here with me at this table. You have already mentioned two of them. They are GAO evaluators. All of them have been working for a long time now, as you know, in the area of home health care for the elderly.

They are: Janet Shikles, who is Group Director at the Institute for Program Evaluation; Tom Dowdal, Group Director, Human Resources Division; Jim Solomon, senior analyst, Institute for Program Evaluation.

With your permission, Mr. Chairman, and in the interests of time, I thought I would summarize only the main points of my full statement and request that the latter be made a part of the record if possible.

The CHAIRMAN. Without objection, we will make your complete statement, which is very detailed and very good, a part of the record following the panel's presentation.

Ms. CHELIMSKY. S. 234 has three major objectives: To expand the coverage of home health services, to stimulate the establishment of home health programs; and to encourage families to provide care for elderly dependents in the home.

The issue involved here, that of access to and availability of home health care, is one that is not only of increasing importance to the elderly and disabled currently in need of these services, but to all of us. The fact is, as we heard earlier, that America's population is aging.

While 25 million Americans, that is, about 11 percent of the population, were aged 65 or older this year, this number is projected, as you know, to grow to 45 million by the year 2020, or between 14 and 18 percent of our total population at that time.

Also, while individuals in our country 65 or older are thus increasing in proportion to the total population, they are also living longer. Of course, the older people grow, the more they tend to need health services, services which are often due to chronic rather than acute health problems.

How best to provide long-term health care to the elderly—health care which can address chronic as well as acute problems, health care which can accommodate what may well be a staggering demand for services without bankrupting the Nation, health care which is effective but which also treats the patient in a holistic way as a human being with diverse, social, medical, and other needs—this is a very complex question, and there are no simple answers.

All the proposed methods we examined in our study for this committee involve making difficult decisions. For example, meeting the health care needs and demands of the elderly must be balanced against the collective national needs and demands for cost containment. Similarly, the desire to reach the unserved or the underserved elderly comes into conflict with the dangers of institutionalizing far and wide an already highly imperfect system.

These are of course policy tradeoffs. The first involves, in Dr. Philip Brickner's words, a choice between "the importance of dol-

lars" on the one hand and, on the other, "the issue of what human beings are entitled to in their lives."

The second tradeoff moves between what some have called "a sleeping iceberg of unmet need" and the equally difficult problems of improving efficiency or controlling fraud and abuse in entitlement programs.

In trying to eliminate some aspects of these tradeoffs, this committee asked the GAO to rapidly examine the likely effects of expanding home health care services. To do this, we synthesized the findings of recent research and evaluation focusing on these effects, performed some site visits and interviews, and sought to produce information on two major subquestions.

These subquestions are: (1) What effects do expanded home health care services have on patient outcomes, that is, on their health, and (2) what effects would expanded home health care services be likely to have on costs?

EFFECTS OF EXPANDED HOME HEALTH CARE ON PATIENT OUTCOMES

First then, what do we know about the effects of expanded home health care on patients' health? To begin with, there is evidence that individuals who receive expanded home health care services live longer than those who use the currently available health services.

Several evaluations with different levels of methodological sophistication support this view. For example, preliminary data from the Georgia Alternative Care Program's randomized control and treatment group study showed a significantly longer survival period for recipients of expanded services over a 24-month study period, as compared to their control group.

We also found general agreement among the studies that patients receiving home care services are more content and that their mental functioning improves.

In the Connecticut triage program which Miss Hayes mentioned earlier, clients' perceptions of their health showed marked improvement. Information from the onlook program, which is in San Francisco, and other studies also suggest improvements in the level of contentment.

On the other hand, it is unclear whether home care services actually increase patients' functional abilities. Some studies report that patients who receive home care improve their functioning. Others report the opposite.

The discrepancy can be explained in a number of ways. The population under study is generally chronically ill with decreased functional abilities. Methodological problems with the evaluations—here I am thinking about attrition in the control group mostly—also makes interpreting the data difficult.

In sum then, evaluations of demonstration projects and other research have found that expanded home health services do attain positive patient outcomes on some measures, perhaps the most critical of which is that older Americans who receive expanded services in their homes tend to live longer.

EFFECTS OF EXPANDED HOME HEALTH CARE ON COSTS

Our second question was: What effects would expanded home health services be likely to have on costs? Although it seems likely, based on our review as I have said, that expanding the types of available home health care services and increasing the numbers of people eligible for this care would improve patient outcomes, it also seems likely that Federal health expenditures would increase, unless those expenditures could be offset by accompanying reductions in institutional costs.

Now the ways in which it has been suggested that such offsets could occur are by reducing hospital admissions or readmissions, and by decreasing length of stay in hospitals and in nursing homes. Home health care would certainly result in cost savings if the frequency of admissions or readmissions to hospitals were reduced. By stabilizing chronic illnesses, for example, home health care could theoretically reduce the need for hospital admissions for the elderly.

However, the question of whether or not expanded home services actually do reduce patient admissions or readmissions is not answered by our review. The studies conflict. Further, it is the studies that use the weakest evaluative techniques that have reported some reductions in hospital admissions through the use of home care, while the studies using more rigorous designs found no savings whatever with home care.

On the other hand, there is evidence that home health care can produce savings with respect to length of stay in hospitals. Studies in the early 1970's had estimated the number of hospital days that could potentially be saved by reducing length of stay through making home health care services available.

Of the nine studies we examined, the estimated average number of hospital days avoided per patient transferred to home services was 13.3 days. (I should probably point out that, of course, some of the savings from this avoidance are already being captured.) The studies reported estimates ranging from an average of 3.5 to 22.6 hospital days saved. These positive findings have been substantiated by more recent and methodologically improved evaluations.

With respect to the nursing home/home health care comparison, it has not been demonstrated conclusively that home health services can reduce the number of days the elderly would otherwise spend in a nursing home. Further, even when the number of days can be reduced, cost saving is not necessarily achieved, as shown by two studies which report fewer nursing home days for the randomized treatment sample, but higher total costs for the extended services. These findings may be explained partly by the relative costs of home health care and nursing home care services. Nursing home rates, specifically if they are paid by medicaid, are low, while home care rates are often as expensive or more expensive, depending on the home services used.

In sum, the cost studies we reviewed suggest, first, that home health care can at a minimum be cost effective for some groups of people or for some services, and, second, that its use can produce cost savings by reducing patients' length of stays in hospitals.

GAPS IN NEEDED EVALUATIVE INFORMATION

In seeking to answer the two subquestions, then, about the effects of expanded home health care on patient outcomes and on costs, we found a certain number of information gaps which available studies were unable to fill. These gaps are in the following areas.

First, there do not appear to be widely used, systematically applied methods for identifying patients already in institutional settings or before they enter the settings who could and would prefer to receive treatment in their own homes, if appropriate home health services were available.

Again, methods for establishing the most cost effective discharge time are lacking. This is part of a larger problem of defining who should be placed in each care setting and when. This clearly affects estimates of cost savings to be achieved through home care since it is difficult to identify individuals receiving too high a level of care.

A second gap we found is that little validated information exists on the care actually received by patients.

Third, there is little knowledge of which reimbursement mechanisms are the most cost effective and the most likely to deter waste, fraud, and abuse.

A fourth information gap is that the effects of home health services on hospital backup are unknown, largely because it has not been determined whether the types of patients backed up in hospitals are in fact candidates for discharge to home health services.

Finally, what the actual cost of an expanded system of home care services would be is unclear. Methodological problems of all types; problems of ethics and design; problems of identifying potential need and demand, not only among institutionalized patients but in the general population; problems of defining supply, all of which have plagued the conduct of research in this area, mean that conclusive information on the cost effectiveness of home care for the total population to be serviced may not easily be attainable.

CONCLUSIONS

Let me conclude then by saying that, in summary, after reviewing a large number of home health care studies and evaluations of demonstration projects, we see improvements in some patient outcomes, such as longer lives and increased contentment. However, the results for other outcome measures such as physical functioning are still uncertain.

Similarly, we find that some health care costs may be offset by reducing patients' length of stay in hospitals, but the cost effectiveness of home health care as a substitute for nursing home care is uncertain.

Finally, the total effect on health costs of expanding home health care services remains unknown.

We can fill some of these current information gaps. We can fill them: One, by examining appropriate placement methods to try to determine what patient or illness characteristics are most economically and effectively dealt with in each care center; Two, by developing methods for early identification of patients who want to

avoid institutionalization through receiving home health care or who are likely candidates for early discharge; Three, by creating mechanisms to insure that services are provided to patients who are most in need and that the services provided actually match the patient's needs, and, last, Four, by finding new or improved reimbursement mechanisms, as S. 234 proposes to do, through the demonstration of a number of different reimbursement techniques.

Mr. Chairman, this completes my summary statement. My colleagues and I would be happy to respond to any questions you may have.

The CHAIRMAN. Thank you, Ms. Chelimsky, Mr. Solomon, Ms. Shikles, and Mr. Dowdal. We appreciate having your testimony here today.

In your testimony, you noted that, while research has been funded in this area, we still have an information gap, particularly concerning cost containment if home health services are expanded. Based on your review of research and knowledge of available techniques, do you think Congress will ever have conclusive information on this issue?

Ms. CHELIMSKY. I think we have to begin by stating that there are major methodological problems, unsolved problems, which are inherent in examining the cost impacts of health service expansion to new unserved or underserved groups of people.

These problems have been responsible for the really lamentable record of the past in trying to estimate cost impacts for other health programs, which, like S. 234, also sought to achieve or improve access to the health care system by particular populations.

Just to remind you how very inadequate these efforts were, let me quote from Senator Russell Long, speaking in 1971 of the problems he had encountered in estimating the costs of medicare:

Our experience with medicare and its own continuing financial crisis attests to the virtual impossibility of estimating costs and utilization when Federal dollars replace private dollars in paying for health care.

Today, by official estimate

of course, he was speaking in 1971

the medicare deficit over the next 25 years is \$242 billion, but to put cost estimates in perspective, it is not reassuring to know that in the entire history of medicare we have never experienced costs below or even near estimated levels.

For example, when medicare was originally enacted in 1965, projected costs for the year 1975 were \$4.3 billion. These 1975 costs are now estimated at \$11.7 billion. Thus, the original estimates for 1975 will be exceeded by \$7.4 billion. For the year 1990, the estimated projected cost when medicare was enacted was \$8.8 billion. Those costs are now projected at \$33.3 billion, quadrupled!

We are now turning to the consideration of new proposals.

Logic and experience indicate the potential margin for error in cost estimates for these proposals.

Why is it so hard to predict costs in these kinds of programs? There seem to be several reasons.

First, the true sizes of demand and supply are unknown. There is uncertainty about the amount of need and about the degree of need. With regard to the expansion of home health services, if the Congressional Budget Office is right, only between 11 and 30 percent of the elderly who need health care are now receiving it. That builds in an enormous potential demand and a likely strain on supply which will send prices zooming. But how much?

This depends on the state of supply, on the competition existing among providers, on the strong inflationary pressures which exist in the health care sector, on the way in which supply is defined as including or excluding the support systems of friends and families, and on outside pressures from the hospital or nursing home industries.

Second, there are methodological problems in attributing costs because of the fuzziness of the unit of analysis we have here, which is the visit—a visit can be 2 hours, a visit can be 24 hours—and because of difficulties in designing new experiments from which one might hope to project cost savings to some population.

The CHAIRMAN. Thank you very much. We have a number of other questions which we would like to submit to you in writing to receive the appropriate responses for the record as soon as possible.

We are very grateful for the efforts you have put forth and for the great work you have done. Thank you so much for being with us.

[The prepared statement of Ms. Chelimsky and responses to question of Senator Hatch follows:]

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

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STATEMENT OF
ELEANOR CHELIMSKY
DIRECTOR, INSTITUTE FOR PROGRAM EVALUATION
BEFORE THE
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE
ON
EXPANDED HOME HEALTH CARE

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

We are pleased to be here today to testify on the issue of home health care and S. 234, the proposed Community Home Health Services Act of 1981. In home health care, as defined under Medicare, patients in their homes are given health services by nurses or therapists and personal care services (bathing, grooming, etc.) by aides. S. 234 proposes to expand the coverage of home health services, encourage the establishment of home health programs, and encourage families to provide care for elderly dependents in the home.

The Chairman asked GAO to assist the Committee in examining the likely effects of expanding home health care services. We focused on

--what effect home care services have on patient outcomes;

--what effect expanded home health care services might have on the number of hospital and nursing home admissions, length of stay and patient discharge; and

--what circumstances might allow home health care to be a cost effective substitute for institutionalization.

Since S. 234 builds on the current home health care system, we first examined some issues or concerns about how this system functions. They are that

--while the use of home health care is expanding, it is still somewhat limited by restrictions on eligibility and service coverage, access problems in some areas, and lack of information on the types of services that are available;

--because of these restrictions, some elderly Americans who need home health care and other community-based services either go without care or seek institutional care as an alternative;

--the way in which home health care services are currently provided needs to be improved because the reimbursement system lacks incentives to minimize costs, the provision of services and funding is fragmented, monitoring service use is difficult and data management is not always effective.

Keeping these concerns in mind, we then looked at the possible effects of expanding home health care services by review-

ing a large number of studies and evaluations that have examined this issue. Although all of these possess at least some methodological flaws, we were able to draw the following conclusions from them:

- Demonstration projects and other research have generally found that expanded community-based services, including home care, attain positive patient outcomes. One of the most critical is that older Americans who receive expanded services in their home may live longer.
- The cost studies we reviewed suggest that home health care can, at a minimum, be cost effective for some groups of people or for some services. For example, reducing patients' length of stay in hospitals would produce savings. While this already occurs to some extent, more can be done.
- However, what the total cost of an expanded system of home care services would be is unclear. Problems of ethics and design in conducting research in this area, mean that conclusive cost effectiveness results for the total population serviced may not be obtainable.

To have a more successful home care system several actions should be taken. Among them are that

- methods should be developed to assure early identification of patients in institutional settings or

before they enter institutions who could and would prefer to receive treatment in their own homes if appropriate home health care services were available;

--incentives should be created so that patients once identified, actually move from institutional settings to alternative care settings when care provided in these settings is cost effective and in accordance with their preferences and their well-being;

--mechanisms are needed to insure that the services provided at home are appropriate to the patients' needs; and

--the adequacy of current reimbursement mechanisms for home health care should be reviewed. We endorse the concept of examining a number of different reimbursement mechanisms through demonstration projects designed to determine if a better reimbursement system can be devised. S. 234 includes a provision for reimbursement demonstrations.

METHODOLOGY

We developed these findings based on a review that combined information collected from interviews with agency officials, experts, and home health care providers with information from site visits and an evaluation synthesis of research in the field. We interviewed Department of Health and Human Services officials,

including those in the Health Care Financing Administration and in the Administration on Aging. We also interviewed health care providers and experts in the home care field. We questioned these people about the general background of the home health care system and its cost effectiveness, its program management and design, and specific details of recently introduced legislation. We combined their answers with what we saw during site visits to 21 home care agencies and programs (listed in appendix I). A number of these were demonstration projects offering expanded services on an experimental basis. We attempted, within our time constraints, to visit a geographically and organizationally diverse set of home care providers.

The major component of our review, however, was a synthesis of existing evaluation studies. The essence of an evaluation synthesis (a method developed by GAO) involves first examining the findings and conclusions of existing evaluations, second, assessing the adequacy of the methods used, and, third, determining, not only the information which is sound and available for policymakers to use, but also the gaps which remain in that information, either because certain questions were not addressed or because the methods were not adequate for addressing them. In reviewing this literature we found a wide range of methodological sophistication among the studies by government agencies, health care providers, and university and contract researchers, as well as our own relevant reports (appendix II lists pertinent GAO reports).

ISSUES CONCERNING THE CURRENT
HOME HEALTH CARE SYSTEM

Our examination of some of the issues relating to how the current home health care system functions, primarily focused on Medicare's coverage of home health care. While the Federal government also funds in-home health or health related services through Medicaid, Title XX of the Social Security Act, and Title III of the Older Americans Act, the largest expenditure is under Medicare.

Medicare's coverage of home health care represents one of the fastest growing health expenditures for the Federal government. It is estimated that in FY82 \$1.146 billion will be spent on Medicare benefit payments for home health services. 1/ This is an increase of about 300 percent over the \$287 million spent in FY76. 2/ The number of Medicare home health visits has also increased from 8.1 million in 1974 to 17.3 million in 1978. 3/

Medicare, authorized by Title XVIII of the Social Security Act (42 U.S.C. 1395), provides a broad health insurance program for most persons aged 65 and over and some disabled persons. Home health services under Medicare, as defined by the Social Security Act include:

- part-time or intermittent nursing care provided by, or under the supervision of, a registered professional nurse,
- physical, occupational, or speech therapy,
- medical social services provided under the direction of a physician,

- part-time or intermittent services provided by a home health aide as permitted by regulations,
- medical supplies (other than drugs and medicine including serum and vaccinations) and the use of medical appliances, and
- medical services provided by an intern or a resident enrolled in a teaching program in a hospital affiliated or under contract with a home health care agency.

To be eligible for home health care coverage under Medicare, a person must essentially be confined to his/her residence (home-bound), be under a physician's care, and need part-time or intermittent skilled nursing care and/or physical or speech therapy. The care must have been prescribed by a physician, and the services furnished must be provided by a participating home health agency (either directly or through arrangements with others) in accordance with the physician's treatment plan.

The availability of home health care is somewhat limited and uneven

Despite the growth in home care expenditures several studies estimate an unmet need for home care. For example, in a recent study the Congressional Budget Office (CBO), focused specifically on measuring the potential need and available supply of home health care. This report included estimates that potentially 1.7 to 2.7 million people were in need of expanded home services, but that only 300,000 to 500,000 were being given such services. 4/ GAO studies, although not projectable to the total elderly population,

have indicated that between 10 and 22 percent of the elderly 65 years and older in some areas or cities were not receiving all the homemaker/chore and personal care services they need. 5/

Some of this unmet need may be partly a result of Medicare's home health care coverage. First, Medicare has few incentives to provide chronic care to the elderly. As currently designed this program provides medically related services to individuals with acute care needs on a temporary basis; excluded therefore are elderly who require additional care over a longer time span. Second, several services that are sometimes necessary for monitoring the elderly in their homes are not provided. Many individuals with long term care needs ideally could use a combination of medical, social, economic and mental health services. The services often cited as needed--homemaker/chore, home delivered meals, transportation and respite care--are the services most commonly not covered by Medicare.

In addition to gaps in service coverage and eligibility, fragmentation and lack of coordination among the numerous community-based programs sometimes prevent people from receiving appropriate care. Access to care is also an issue in rural areas where home care services may be in short supply or not be available at all. Lack of information on non-institutional long-term care options also restricts use. For example, GAO reported in 1979 that families lack information on community-based alternatives because they do not have the time to explore the availability of community services and because hospital discharge planners do not

have enough time to assess patients' needs and arrange appropriate placement. 6/

Many elderly may not be receiving care
in the most appropriate setting

Another difficulty in the current system is in trying to assure that all health providers--home health care, hospital care, and nursing homes--work together so that a patient receives care in the setting most appropriate to need, individual preference, as well as most reasonable in terms of cost. This does not always occur. Avoidable institutional use includes elderly residing in hospitals or nursing homes who do not need (and in some cases do not desire) the level of care provided, but remain for lack of alternative placement options. Some of these individuals could be released to or could have remained in their homes if community services were available.

Avoidable institutionalization occurs partly because no one has yet adequately defined who should be placed in each care setting. It has already been demonstrated that some people in nursing homes could have remained in their communities with appropriate services. Due to errors in the estimates and problems with assessments it is difficult to identify the actual number of individuals receiving too high a level of care. However, we do know that a problem exists.

Elderly are also unnecessarily residing in acute care hospitals. It has been estimated, for example, that nationally 17,783 people or 6.9 percent of the Medicare and Medicaid patients in acute care hospitals surveyed were awaiting placement elsewhere. 7/

Some of these patients are considered to be potential candidates for home care if the necessary services were made available.

Problems exist in program
design and management

Under Medicare, the reimbursement system is relatively open-ended and susceptible to abuse. Moreover, some home care providers lack sophisticated data base management, making review of their operations difficult. Further, fiscal intermediaries do not receive adequate information, nor do they monitor agencies closely enough to insure that the services that are claimed are reimbursable and that the services that are provided go to those most in need.

The reimbursement system, in particular, has been widely criticized as "lacking incentives to providers to be efficient and minimize their costs." 9/ Two problems with it include:

- wide variations in the unit costs of similar services and the related problems in determining whether costs at the higher end of the range are reasonable; and
- problems in determining the allowability of costs claimed and their relationship to patient care. 9/

A report just issued by the Permanent Subcommittee on Investigations of the Senate Committee on Governmental Affairs found that for Medicare's home health care benefit the "current retrospective cost reimbursement system as it applied to not-for-profit agencies, lends itself to fraud, waste and abuse." 10/

The recordkeeping procedures of some providers may not be detailed or sophisticated enough to generate the information that is necessary to determine whether services that have been claimed can be reimbursed. GAO has reported data from the Health Care Financing Administration that shows that "8 percent of the certified home health agencies fail to maintain adequate clinical records." 11/ The report states, further that the documentation fiscal intermediaries receive gives them little or no information on which to base their decisions.

EFFECTS OF EXPANDED SERVICES

The inadequacies of the current home care system just described, have been the subject of concern by Congress, the Federal and State governments and others for some time. In response to some of these inadequacies, a number of demonstration projects and other studies have been conducted. Primarily, they have addressed ways to expand and target services, the costs of expanded services, and what services should be provided. In response to this Committee's Chairman, therefore, we reviewed these demonstrations and studies to find out what is known about the effects that expanding home health care would have on patient outcomes; the effects of expanded services on the number of hospital and nursing home admissions, length of stay and patient discharge; and the extent to which expanded home health care can be a cost effective substitute for institutionalization.

Research efforts to examine the effects
of expanded services are hindered
by methodological concerns

Our efforts to examine these issues were hindered somewhat by methodological concerns we have about the studies and demonstrations. We found few well-designed, controlled studies. We found many case studies (examinations of a single group of recipients), some comparison group studies, and a few randomized control group experiments. Information from well-designed control group experiments is, however, the most useful and has the greatest generalizability, since threats to external validity are minimized. In the studies we reviewed, we also identified a number of methodological problems, including problems of definition, sampling, and client assessment.

Definitional problems

The definitional problems in the home health care area are so all-encompassing that even the definition of "home care" itself is confusing. Thus, comparing various home health care evaluations is difficult because each defines home health care to describe its individual situation. Some evaluations of home care include people in day care centers while others include or exclude homemaker services, home health aide care, or some other specific services. The service mix is often not specified in the report. Therefore, the differences of service mix among different studies make comparisons difficult. Furthermore, there is no consistent definition of a "home health care visit." A visit can be as different as a 10-minute stop by a skilled nurse or a 2-hour health aide visit. In some cases a visit could be a 24-hour live-in nurse service.

Determining costs in different health care settings suffers from methodological problems, too. Many evaluations fail to consider the value or costs of services provided informally by families, or formal support provided by other Federal programs. This failure is critical because services that families and friends provide are similar to those that agencies provide. In an earlier report, GAO stated that families and friends provide more than 50 percent of the services at all impairment levels. The families and friends' portion of home services provided reaches 80 percent at the extremely impaired levels. ^{12/} Support provided by other Federal programs such as Supplemental Security Income, Title XX, and other Federal benefits, are often not considered when comparing institutional to noninstitutional settings.

Sampling issues

Even the best-planned and implemented evaluations may contain sampling problems. Probably the most common problem that has a seriously adverse effect on validity is attrition; that is, members of the control groups die or move from the study area at a higher rate than members of the treatment group. If control group members die at a higher rate, the experimental group grows proportionately older and more infirm than the control group. Subsequently, the experimental group may use proportionately more services and have a higher per case cost. Attrition becomes more important for studies with longer time frames.

Client assessment issues

A number of evaluations we reviewed also have some drawbacks with respect to client assessment. Each study typically uses its own client assessment forms and categories, making it difficult to compare clients across studies even when the clients seem to have similar disabilities and disease levels. Moreover, client assessments are often performed by the home health care providers, but the reliability of these assessments is questionable. Finally, in a number of studies the hypothetical differences in cost of services provided and subsequent savings between settings are based on physicians or the health providers' estimates. These estimates may be inaccurate.

Current studies provide some helpful information

These methodological problems make interpreting the evaluations difficult. However, in spite of these problems much can be learned from this work. We will now discuss some of the information we were able to derive from these evaluations.

Studies and evaluations we reviewed suggest that increasing home care services can provide improved patient outcomes on some measures. Three outcome measures will be discussed: patient life span, patient contentment and patient functioning levels.

Patients receiving expanded home care live longer

There is evidence that individuals who receive expanded home health care services live longer than those who use the currently available health services. Two evaluations of different long-term

care demonstrations that used an experimental design corroborate this view. Preliminary data from one randomized control and treatment group study showed a statistically longer survival period for recipients of expanded services as compared to a control groups' mortality rate. Over a 24 month period, the treatment group lived longer than the control group. 13/ These findings are supported by a second study, of one year duration, that also reported statistically significant differences between a homemaker, and combined homemaker-day care sample's mortality rate when compared to a control group's. 14/ In both studies, recipients of enriched home care or alternative services lived significantly longer than control groups when traditional services were available.

Home care increases
patient contentment

There is general agreement that patients receiving home care services are more content and their mental functioning also improves. In the Triage program, clients' perceptions of their health showed marked improvement. Information from the On Lok program and other studies also suggests improvements in the level of contentment.

Evidence on increased patient
functioning is inconclusive

Whether home care services actually increase patients' functional abilities is unclear. Some studies report that patients who receive home care improve their functioning; others report the opposite results. The discrepancy can be explained a number

of ways. The population under study is generally chronically ill, with decreased functional abilities. Further, in studies using control or comparison groups members of these groups may die at a proportionately higher rate than members of the experimental groups. To the extent that this occurs the experimental groups therefore will have a higher proportion of the elderly, infirm, and dysfunctional patients, since they live longer.

Results from an evaluation of the functioning of individuals placed under either home health or nursing home care services reported a greater improvement in the home care sample's level of functioning. ^{15/} Patients treated in the On Lok demonstration also showed some improvement or no change in activities of daily living. ^{16/} On the other hand, a more recent study using a rigorous design indicated a deterioration in the physical activities of daily living for the experimental group. ^{17/} This study examined a long term demonstration program in Chicago offering comprehensive services that included physician's visits and chore service. The experimental group, however, was older than the comparison group for this study. This may explain their lower levels of functional abilities.

Can costs be contained if
services are expanded?

It seems likely, based on our review, that expanding the types of available home health care services and increasing the numbers of people who would be eligible for this care would increase Federal health expenditures. It has been hypothesized however, that some of the increase would be offset by the

accompanying reductions in institutional costs. We reviewed the research and evaluations to examine whether expanded home care services can be provided cost-effectively and how the appropriate placement of patients can aid this cost reduction or containment.

Home care can reduce
hospital length of stay

Studies in the early 1970s used the judgments of physicians and other experts to estimate the number of hospital days that could potentially be saved by making home care services available. Of the nine studies we examined, the estimated average number of hospital days avoided per patient transferred to home services was 13.3 days. These studies reported estimates ranging from an average of 3.5 to 22.6 hospital days saved. ^{18/} This positive finding is substantiated by more recent and methodologically improved evaluations. For example, a 1976 study using randomly assigned treatment and control groups reported an average length-of-stay reduction of between one and 3.5 days for the experimental group in 5 of 13 diagnostic groups, without compromising clinical outcomes. ^{19/}

Since the Federal government paid 41 percent of the nation's \$85.3 billion hospital bill in 1979, any reduction in days paid for would potentially produce savings. ^{20/}

The effects home care has on
hospital admission/readmission
rates are inconclusive

One way home care could result in hospital cost savings is by reducing the frequency of admissions or readmissions to hospitals. By stabilizing chronic illnesses home care could

theoretically reduce the need for hospital admissions for the elderly. However, whether or not expanded home care services actually reduce patient admissions and readmissions is not clear. Studies that relied on estimating techniques reported a small number of hospital days saved by home care, while studies using more rigorous designs find no savings with home care. Two other studies reported an increase in institutional utilization. We are unable to draw conclusions because of design problems and conflicting findings in these studies.

Findings from some relatively well designed studies (although not without flaws) suggest that community placement has no effect on hospital admission and readmission rates. Preliminary statistics released from a Health Care Financing Administration demonstration project indicate that there was no statistically significant difference in the use of in-patient services between randomly assigned community care recipients and the control group. 21/ Another researcher reported similar results using randomly assigned treatment and control groups. Elderly clients receiving several additional services showed no difference in hospital use when compared to members of a control group receiving traditional services. 22/

Other studies that had randomly assigned treatment and control groups did find that the treatment group was significantly more likely to be institutionalized than the control group. In these studies the observed higher hospital use for the home care sample was attributed to the detection and treatment of illnesses

that otherwise would have gone unreported. 23/ One study termed this phenomenon "social visibility," where at-risk clients come in contact with a service system and are more likely to be encouraged to enter institutions sooner. 24/ Although this may be an area of expanded use of services and increased costs, it could provide care to the elderly who would not otherwise be served.

The effects of home care on
hospital backup are unknown

Hospital backup is a special case of appropriate placement. This refers to patients in acute care hospitals awaiting transfer to chronic care settings. These patients are referred to as occupying "administratively necessary day beds". Annual surveys of New York hospitals indicate that this problem is severe and getting worse. In 1979 there were 3,961 Medicare/Medicaid patients awaiting alternative placement; in 1980, there were 4,424. The average wait for these patients increased from 53 days in 1979 to over 74 days in 1980, a 40 percent increase in one year. 25/

A number of people have hypothesized that availability of home care services can provide alternative placement for backed-up patients. However, little work has been done to test this hypothesis and whether the type(s) of patients backed-up in hospitals are candidates for discharge to home care is unknown. From the patient descriptions provided in two studies, it is difficult to tell if these patients were inappropriate hospital placements. We still do not know if, or to what extent, expanded home care can reduce hospital back-up. However, this may be a promising area for future work.

Additional work on alternatives
to hospitalization is needed

One area for potential cost savings has received little attention or research. Some hospitalized patients, not classified as backed up may be likely candidates for returning home early. These patients, such as those needing minimal care and monitoring, could be discharged early to recuperate in their homes if appropriate home health services are available. Due to the high cost of hospital care, some savings may consequently be realized by any early discharge. The problem in implementing this approach, however, is that no adequate methodology for identifying such patients currently exists. One recent study of home health care concluded that even under Medicare there is little agreement in the field as to what kind of discharge service is required for elderly persons who are possible candidates for home health care. It noted that currently "hospitalized patients (are) dependent upon a very uncoordinated, and in some instances even haphazard system identifying their need." 26/

Reduced placement in nursing homes
suggests little or no cost savings

It has not been demonstrated conclusively that home care services can reduce the number of days the elderly would otherwise spend in a nursing home. While some studies reported reduced nursing home use for the treatment group, it is difficult to attribute the observed difference between the treatment and comparison group to the program due to methodological problems.

Cost-saving is not necessarily achieved as indicated in two studies reporting fewer nursing home days for a randomized treatment sample but higher total costs for the extended services. 27/

Such findings may be explained partly by the relative costs of home health care and nursing home care services. Nursing home rates, specifically if paid by Medicaid, are fairly low while home care rates are often as expensive or more expensive depending upon the home services used. Estimates of the cost of a day of nursing home care in 1979 ranged from \$21 to \$56 per day. 28/ Due to the number and frequency of services a home care recipient needs, costs for this care may often exceed these rates on a daily basis.

The uncertainty about differences in the cost of serving someone in the community versus in a nursing home was raised in a recent Department of Health and Human Services study. A review of research which assessed candidates for care in either setting seemed to indicate that for slightly impaired people alternatives other than nursing homes are more economical, but that for severely impaired people the opposite is true. They noted, however, that what is not yet known is "exactly where the breakeven point occurs, and how to determine for which individuals and subpopulations which particular services and settings are cost-effective." 29/

CONCLUSIONS

Despite a large number of home health care evaluations and demonstration projects our knowledge of the effects of expanding home care is still limited. While we see improvements in some patient outcomes such as longer lives and increased contentment,

the results for other outcome measures such as physical functioning are still uncertain. Similarly, we find that some home health care costs may be offset by reducing patients' length of stay in hospitals as already occurs to some extent. However, more can be done. The cost effectiveness of home care as a substitute for nursing home care is unknown. The total effect of expanding home health care services on health costs is not known, and it may never be known.

We can fill some of the current information gaps by

--examining appropriate placement to try to determine what patient or illness characteristics are most economically and effectively dealt with in each chronic care setting.

--developing methods for early identification of patients who can avoid institutionalization by receiving home health care or are likely candidates for early discharge.

--developing mechanisms to insure that services are provided to patients who are most in need and that the services provided actually match these needs.

--examining through demonstration programs if improved reimbursement mechanisms can be developed.

This concludes our statement. We would be pleased to explain any part of it or to answer any questions you may have.

APPENDIX I

APPENDIX I

HOME CARE AGENCIES AND PROGRAMSVISITED OR CONTACTED

San Francisco Home Health Services, Inc., San Francisco, California

Mt. Zion Hospital and Medical Center, San Francisco, California

California Association for Health Services at Home, Arcadia, California

Los Angeles Visiting Nurse Association, Los Angeles, California

Senior Health Care Program, Harborview Medical Center, Seattle, Washington

Seattle Visiting Nurse Association, Seattle, Washington

University of Washington Institute on Aging, Seattle, Washington

Chelsea Village Program, New York, New York

Long-Term Home Health Care Program, Metropolitan Jewish Geriatric Center, Brooklyn, New York

Visiting Nurse Association of Boston, Boston, Massachusetts

Community Long-Term Care Project, Spartanburg, South Carolina

Alternative Health Services Project, Atlanta, Georgia

Upjohn of Georgia, Atlanta, Georgia

Ketona Program, Jefferson County Department of Health, Birmingham, Alabama

Community Nursing Services of Salt Lake City, Salt Lake City, Utah

Holy Cross Hospital of Salt Lake City, Salt Lake City, Utah

Denver Upjohn, Denver, Colorado

Triage, Inc., Plainville, Connecticut (NV) 1/

Monroe County Long Term Care Program, Inc., Rochester, New York (NV)

Pittsburgh South Hills Home Health Systems, Pittsburgh, Pennsylvania (NV)

1/NV: Interviews conducted and extensive information collected, but project site not visited.

APPENDIX II

APPENDIX II

SUMMARY OF GAO REPORTS ISSUED ON
MATTERS RELATED TO IN-HOME SERVICES

<u>Report title</u>	<u>Date of issue</u>
Returning The Mentally Disturbed To The Community: Government Needs To Do More (HRD-81-152A)	January 7, 1977
The Well-Being Of Older People In Cleveland, Ohio (HRD-77-70)	April 19, 1977
Home Health--The Need For A National Policy To Better Provide For The Elderly (HRD-78-19)	December 30, 1977
State Programs For Delivering Title XX Social Services To Supplemental Security Income Beneficiaries Can Be Improved (HRD-79-59)	April 11, 1979
Home Health Care Services-- Tighter Fiscal Controls Needed (HRD-79-17)	May 15, 1979
Conditions Of Older People: National Information System Needed (HRD-79-95)	September 20, 1979
Conditions And Needs Of People 75 Years Old And Older (HRD-80-70)	October 15, 1979
Entering A Nursing Home: Costly Implications For Medicaid And The Elderly (PAD-80-12)	November 26, 1979
Evaluation Of The Health Care Financing Administration's Proposed Home Health Care Reimbursement Limits 1/ (HRD-80-84) (HRD-80-85)	May 8, 1980

1/Letter report to the Honorable Bob Packwood and the
Honorable Sam M. Gibbons.

Report title
Comparison Of Data On Older
People In Three Rural And Urban
Locations 2/ (HRD-80-83)

Date of issue

May 23, 1980

Medicare Home Health Services:
A Difficult Program To Control
(HRD-81-155)

September 25, 1981

2/Letter report to Chairman, Federal Council on Aging.

NOTES

- 1/ K. Reiss, Federal Programs That Finance Home Health Care Services (Washington, D.C.: Congressional Research Service, March 1981), p. 3.
- 2/ Medicare Home Health Services: A Difficult Program to Control, U.S. General Accounting Office, HRD-81-155, September 25, 1981, p. 1.
- 3/ Ibid, p. 6.
- 4/ Long-Term Care for the Elderly and Disabled (Washington, D.C.: Congressional Budget Office, August 1977), p. x.
- 5/ Improved Knowledge Base Would Be Helpful in Reaching Policy Decisions on Providing Long-Term In-Home Services for the Elderly, U.S. General Accounting Office, HRD, forthcoming, p. 1.
- 6/ Entering a Nursing Home: Costly Implications for Medicaid and the Elderly, U.S. General Accounting Office, PAD-80-12, November 26, 1979, p. 64.
- 7/ American Association of Professional Standards Review Organizations, "Long-Term Care One-Day Census" (September 4, 1980), p. 4.
- 8/ Response to the Senate Permanent Subcommittee on Abuse in the Home Health Care Industry, U.S. General Accounting Office, HRD-81-84, April 24, 1981, p. 1.
- 9/ Ibid.
- 10/ U.S. Senate, Home Health Care Fraud and Abuse, Report of the Committee on Governmental Affairs, Permanent Subcommittee on Investigations, October 19, 1981, p. 43.
- 11/ Medicare Home Health Services, p. 31.
- 12/ Home Health: The Need for a National Policy to Better Provide for the Elderly, U.S. General Accounting Office, HRD-78-19, December 30, 1977, p. 17.
- 13/ Personal communication on September, 1981 updating the paper by F. A. Skellie, G. M. Mobley, and R. E. Coan, entitled "Cost Effectiveness of Community Based Long Term Care: Current Findings of Georgia's Alternative Health Services Report," presented to the Annual Meeting of the American Public Health Association, Detroit, Michigan, October 19-23, 1980, table 2.

- 14/W .G. Weissert, T. T. H. Wan, and B. B. Livieratos, "Effects and Costs of Day Care and Homemaker Services for the Chronically Ill: A Randomized Experiment," U.S. Department of Health, Education, and Welfare, 1979, pp. 27-29.
- 15/S. L. Hughes, Evaluation of a Comprehensive, Long Term Home Care Program for Chronically Impaired Elderly (Evanston, Northwestern University, 1981), p. 45, citing a 1978 study by Janet B. Mitchell entitled "Patient Outcomes in Alternative Long Term Care Settings."
- 16/M. Stassen and J. Holahan, A Comparative Analysis of Long Term Care Demonstrations and Evaluations (Washington, D.C.: The Urban Institute, September 1980), p. 110.
- 17/Hughes, p. 3.
- 18/Compilation of results from Michigan Blue Cross, 1976; Berger, 1971; Schutchfield et al. 1971; Rawlinson, 1972; Associated Hospital Service of New York, 1972; Connecticut Blue Cross, 1975; Good Samaritan Hospital, Cincinnati, Ohio, 1976; Denver VNA, 1976a; and Denver VNA, 1976b--as reported in T. Hammond, "Home Health Care Cost Effectiveness: An Overview of the Literature," Public Health Reports, Vol. 94 (August 1979), p. 2.
- 19/L. W. Gerson and P. E. Berry, "Psycho-Social Effects of Home Care: Results of a Randomized Controlled Trial," International Journal of Epidemiology, Vol. 5 (1976), pp. 162-63.
- 20/M. S. Freedland and C. E. Schneider, "National Health Expenditures: Short-Term Outlook and Long-Term Projections," Health Care Financing Review (Winter 1981), p. 106.
- 21/See Skellie, Mobley, and Coan, table 1.
- 22/Weissert, Wan, and Livieratos, pp. 27-29.
- 23/B. Hicks et al., "Triage Experiment in Coordinated Care for the Elderly," American Journal of Public Health, Vol. 71, (September 1981), p. 998, in Hammond, p. 310.
- 24/M. Bleckner, M. Bloom, and M. Neilson, "A Research and Demonstration Project of Protective Services," Social Casework (October 1971), p. 495.
- 25/American Association of Professional Standards Review Organizations, p. 7.
- 26/Office of Service Delivery Assessment, In-Home Services to the Elderly--A Service Delivery Assessment, U.S. Department of Health and Human Services, Office of Inspector-General, September 1981 (Draft), p. 9.

27/Skellie, Mobley, and Coan, p. 8, and Wiessert, Wan, and Livieratos, pp. 28-30.

28/Unpublished data, U.S. General Accounting Office, September 1981.

29/Working Papers on Long-Term Care, U.S. Department of Health and Human Services, Office of Assistant Secretary for Planning and Evaluation, October 1981, p. 103.



UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

INSTITUTE FOR PROGRAM
EVALUATION

November 17, 1981

The Honorable Orrin G. Hatch
Chairman, Committee on Labor and
Human Resources
United States Senate

Dear Mr. Chairman:

Here, in response to your request of November 10 last at the Senate Labor and Human Resources Committee hearing on home health care (S. 234), are my replies to the questions you have posed. I particularly draw your attention to the discussion of the issues raised with regard to the proposed reimbursement demonstrations (Question Number 4) because some of the problems noted in my answer are quite important but could not be addressed at the hearing for lack of time.

Please also find enclosed a copy of my abbreviated oral statement for the Committee's use in preparing the transcript.

It was a great pleasure to learn that the Committee is content with the help GAO has given in developing the substantive issues involved in home health care. We feel that it is a privilege to assist the Committee in its efforts, and we will be happy to help further in any way possible.

With kind regards,

Sincerely yours,

Eleanor Chelmsky
Eleanor Chelmsky
Director

Enclosures: Abbreviated Testimony
Questions and Replies

Question #1: In your testimony you noted that while research has been funded in this area, we still have an information gap particularly concerning cost containment if home health services are expanded. Based on your review of research and knowledge of available techniques, do you think Congress will ever have conclusive information on this issue?

I think we must begin by stating that there are major unsolved methodological problems inherent in examining the cost impacts of health service expansion to new, unserved, or underserved groups of people. These problems have been responsible for the really lamentable record of the past in trying to estimate cost impacts for other health programs which -- like S. 234 -- also sought to achieve or improve access to the health care system by particular populations. Just to remind you of how very inadequate these efforts were, let me quote from Senator Russell Long speaking in 1971, of the problems he'd encountered in estimating the costs of Medicare:

Our experience with Medicare and its own continuing financial crisis attests to the virtual impossibility of estimating costs and utilization when federal dollars replace private dollars in paying for health care. Today, by official estimates, the Medicare deficit over the next twenty-five years is \$242 billion. But to put cost estimates in perspective, it is not reassuring to know that in the entire history of Medicare we have never experienced costs below or even near estimated levels. For example, when Medicare was originally enacted in 1965, projected costs for the year 1975 were \$4.3 billion. These 1975 costs are now estimated at \$11.7 billion. Thus, the original estimates for 1975 will be exceeded by \$7.4 billion. For the year 1990, the estimated projected cost when Medicare was enacted was \$8.8 billion. Those costs are now projected at \$33.3 billion! Quadrupled! We are now turning to the consideration of new proposals. . . Logic and experience indicate the potential margin for error in cost estimates for those proposals.

Why is it so hard to predict costs in these kinds of programs? There are several reasons.

First, the true sizes of demand and supply are unknown. There is uncertainty about the amount of need and about the degree of need. With regard to the expansion of home health services, if CBO is right, only between 11 and 30 percent of the elderly who need home health care are now receiving it. That builds in an enormous potential demand and a likely strain on supply, which will send prices zooming. But how much? This depends on the state of supply, on the competition existing among providers, on the strong inflationary pressures existing in the health care sector, on the way in which supply is defined (as including or excluding the support systems of friends and family) and on outside pressures (from the hospital or nursing home industries, for example).

Second, there are methodological problems in attributing costs because of the fuzziness of the unit of analysis, which is the visit, and because of difficulties in designing good experiments from which one might hope to project cost savings to some population.

Question #2: You mentioned that one of the major problems we face in home health care is that some patients who could benefit from services fail to get identified at all or early enough to have maximum beneficial impact. You also noted that this is where cost savings may exist if services are expanded. Could you elaborate on this problem?

There are at least two problems: one of early identification and one of discharge mechanisms, and they are related. The problem is that there currently are no widespread, systematically employed mechanisms that we have observed or reviewed, for identifying those patients who could benefit from home health care, either:

- before being institutionalized
- during institutionalization or
- at the discharge point.

Yet some patients who need minimal care and monitoring are institutionalized unnecessarily, or are retained in acute care beds when they don't need to be, or remain institutionalized long after they could have been discharged to recuperate in their own homes, if appropriate home health services were available.

Given that the Federal government pays 41 percent of U.S. hospital costs every year, and given also that our evaluation synthesis has shown that home health services may have their biggest payoff in reducing hospital length-of-stay, it seems reasonable to advocate developing assessment methods which can improve the choice of care-settings so that they are more appropriate to the particular needs of patients.

Question #3: We are aware that the Institute is also engaged in a study of nursing home reimbursement and bed supply under Medicaid. Based on this work, do you see the role of home health changing in the future?

What we have been finding is the slowing down of nursing home bed supply growth. This is happening because:

- Medicaid pays much of the Nation's nursing home bill (Medicaid financed 49 percent of the total \$18 billion in 1979);
- Medicaid is in part funded by the states; and,
- Because Medicaid is experiencing budget cuts and because of already existing budgetary deficits at the state level, states are reducing Medicaid expenditures by
 - freezing bed supply in nursing homes, and by
 - discouraging utilization.

The likely effect of this, if it is true -- and I must ask you to note that these findings are still preliminary -- is that home health care could find itself under increasingly heavy pressure, with an even greater demand for services than would normally have been the case (because of the already large estimated size of the unserved or underserved elderly and needy populations).

Question #4: You indicated support for the concept of testing improved methods for reimbursement of home health care services. Do you have recommendations for how this might be implemented?

First, let me say again that I warmly applaud your decision to include demonstrations of reimbursement methods in S. 234, and one of the reasons I applaud it is that I am troubled about what I see as major possibilities for fraud and abuse in this program. I see these based on the GAO's prior findings, on the findings of the Senate Permanent Subcommittee on Investigation in its report on Home Health Care Fraud and Abuse, and on my own experience in evaluating entitlement programs.

These demonstrations which S. 234 proposes can allow us, if we so choose, the opportunity not only to look at the impacts of reimbursement methods on provider and market incentives, not only to look at their impacts on the quality of care, but also to look at these methods in terms of their vulnerability to fraud and abuse.

Each reimbursement mechanism should be planned to comport its own deterrence system. The experience of the past allows us little excuse if we fail to build in, depending on the recognized weaknesses of each particular mechanism (and all mechanisms have at least some weaknesses), the four conditions of deterrence, which are:

- extremely precise definitions and regulations;
- strong internal controls or checks;
- adequate, routine, fiscal and care-quality monitoring;
and
- administrative sanctions which can be regularly and swiftly performed.

We should not make the mistake in these demonstrations, as we have so often done in the past, of failing even to consider the possibility of fraud and abuse at the planning stage. In this context, it will be crucial, for example, to add in the heavier costs of monitoring that will be required to control fraud and abuse in those reimbursement mechanisms, such as prospective budgeting, which provide relatively more opportunity for improper exploitation. (For example, in prospective budgeting, an item may be planned for but not executed; this requires that routine and continual follow-up to ensure accountability be built in.)

Another important point, I think, has to do with drawing, in these new demonstrations, on the lessons from the demonstration evaluations of the past. One promising finding from these studies (see, for example, the study on TRIAGE in Connecticut, or ACCESS in Monroe County, New York, and also the University of Washington's Institute on Aging study) is that case management may be a useful mechanism for the kind of effort at assessment, screening, allocation of resources, and monitoring which are needed for overall program effectiveness and cost containment.

A third point is that, given the need to encourage competition among providers so as to keep costs down, it may also be important to consider the impact of reimbursement mechanisms on maintaining the viability of all five major types of home health providers:

- Visiting Nurse Associations (VNAs)
- Public Health Departments
- Private non-profit corporations
- Hospital-based providers, and
- Proprietary providers.

There currently seem to be fewer and fewer Public Health Departments involved in home health care.

Fourth, and again thinking about the question of competition, it might be useful to include the examination of at least one form of consumer subsidy (vouchers, perhaps) among the proposed reimbursement demonstrations -- for those cases where such activity by patients is possible and feasible.

Finally, it would be a good idea, I think, to look again at the retrospective reimbursement mechanism with the idea of correcting the problems of definition (what does "homebound" mean? what is "reasonable cost"?), the open-endedness, the questionable provisions, and so forth. While these problems have been harshly criticized, many of them seem to be susceptible to improvement or even solution and it seems worthwhile to try a retrospective system one more time, given that it has the advantages first, of lesser vulnerability to fraud and abuse when it is correctly applied, and second, freedom from the vagaries and uncertainties of planning estimates.

Question #5: We have a clause in our bill which provides for up to a \$500 tax credit for individuals who provide health care for elderly individuals in their own homes. Has the GAO assessed the merits of any other tax relief mechanisms such as itemized deductions for elderly health care expenditures, personal exemptions or income adjustments?

IPE is currently undertaking an evaluation synthesis which examines the merits of various tax relief mechanisms. The implementation of any one of these mechanisms depends on the primary objective for choosing such an alternative. One reason to suggest legislation of this kind is to encourage and provide tax relief to taxpayers who already make room for elderly relatives in their homes. A second reason is to provide an incentive for people not to place their elderly relatives in institutions, so as to relieve taxpayers of the expense of long-term health care.

Now, if the purpose is to provide tax relief to all caretakers of elderly relatives, the best alternative appears to be the tax credit, since even if the taxpayer's income is too low to realize the full benefit of the credit, a credit can be refundable. According to the data, this mechanism seems to provide the most relief to the largest number of taxpayers. Tax credits also appear to be the most efficient and equitable method. Unfortunately, it is also the most costly alternative.

On the other hand, if the stated objective is a move toward deinstitutionalization, then itemized deductions, personal exemptions, or income adjustments would suffice. The benefits of these mechanisms are relative to the taxpayer's income bracket: the higher the income, the greater the benefits. An advantage here

is that relatively speaking, exemptions are easier to administer than tax credits. Additionally, the cost of each of these alternatives would be less than that of tax credits. The drawback to these mechanisms, however, is that they benefit a substantially smaller number of taxpayers, practically excluding the impoverished who may have the greatest need of help. Thus far, to our knowledge, Oregon is the only state that has enacted tax credit legislation for long-term elderly health care. Since it has only been effective since 1980, however, cost data have not been made available yet, but an official at the Oregon Office of Aging has suggested that there may be some problem in getting people to take advantage of the credit which is, at maximum, \$250. It is unknown as yet whether the problem involves lack of information, or whether the ceiling on income for the caretaker (\$17,500) and for the elderly person (\$7,500) alike is slowing response, or whether something else entirely is involved.

Idaho has passed legislation for tax year 1981 providing for a standardized deduction or a cash grant in lieu of the deduction. The amount of the deduction is \$1,000 per elderly relative (to a maximum of three). Again, no cost data are available to date.

Question #6: Under the Omnibus Reconciliation Act of 1981, signed into law August 13, 1981, the Secretary of HHS must establish utilization guidelines for home health services provided under Medicare. You state in your report that GAO recommends to the Secretary that national home health utilization guidelines should serve as a basis for determining when a copy of the medical file is to be submitted with a claim for payment. Do you have further recommendations for the Secretary when he establishes these guidelines?

The utilization of Medicare home health services needs to come under much closer scrutiny by the Health Care Financing Administration and its intermediaries. Crucial to the integrity of any reimbursement system is proper documentation. Further, given the emphasis placed on the proper utilization of home health services by the Omnibus Reconciliation Act of 1981, the adequacy of documentation is all the more important. Adherence to the documentation requirements, as well as the requirements themselves, should be improved.

However, the need to get more records must be balanced against the burden and administrative cost of the additional paperwork. Therefore, we suggest that rather than send medical files forward for all cases, that medical files be forwarded to the fiscal intermediaries when the reimbursement limit exceeds the national guidelines and, for a sample of a predetermined size, of services provided to beneficiaries which do not exceed stated norms.

Most intermediaries use some type of screen or combination of screens which can take on many forms. For example, a claim would be reviewed at a higher level if

--for a given diagnosis, skilled nursing visits exceeded a norm on either a weekly, monthly, or bimonthly basis;

--a patient has a certain diagnosis, such as diabetes, which in itself would not establish his or her homebound status;

--treatment exceeded a given number of months since care was initiated, or

--the claims were being submitted by a new provider.

While we did not recommend numerical levels for these screens, we do feel that some type of screening mechanism needs to be used.

In our report we also recommended that the Secretary of HHS direct the Administrator of HCFA to

--clarify and make more specific the criteria for determining homebound status;

--clarify the criteria on the use of aides for homemaker type services;

--require that the estimated cost of the home health services to be provided be placed in the authorizing plan of treatment and recertification;

--inform physicians of the overutilization of the home health benefit, program requirements, and their role in authorizing services; and

--expand and improve on the use of comparative analysis techniques to identify aberrant home health utilization patterns.

The CHAIRMAN. I am delighted to welcome my distinguished colleague from Iowa to our hearing this morning. Senator Jepsen, we are very pleased to have you with us.

I know Senator Jepsen shares my concern for the health of the American families. He is the author of the Family Protection Act, S. 1378, in which he has very successfully focused our attention on several important issues of concern to American families.

The families are the great strength of our Nation, and if families are strong and family relationships are positive and helpful, many of the problems we face today can be significantly diminished. Because I share Senator Jepsen's concern for families, I have been pleased to be included as a cosponsor of the Family Protection Act.

Senator Jepsen, although there are many important issues dealt with in the Family Protection Act, there is one particular provision which is of interest to us today. You have incorporated this provision into a separate bill, S. 1581. These measures deal with tax incentives which would encourage home health care for our elderly.

I compliment you on your foresight and leadership in this important area, and, before turning the time to you, I would like to compliment you on all the work you have done to strengthen America's families. I know it is not always easy, and I know we are sometimes subjected to unwarranted criticism. I want you to know that I feel that the tax provision for home health care for the elderly is typical of so many good ideas you have championed. I trust that this and many others will be enacted as they receive their proper hearing.

We will turn to you at this time, Senator Jepsen.

STATEMENT OF HON. ROGER JEPSEN, A U.S. SENATOR FROM THE STATE OF IOWA

Senator JEPSEN. Thank you, Mr. Chairman. It is a pleasure to appear before the Labor and Human Resources Committee to testify on S. 234, the Community Home Health Services Act of 1981. I know the idea of promoting health care has been a long-time interest of the distinguished chairman of this committee, and I commend him for his efforts. I would like to ask the chairman that I be listed as a cosponsor of the bill.

The CHAIRMAN. I would be happy to do so.

Senator JEPSEN. While I believe your entire bill moves health care services in the right direction, I am particularly interested in that section of your bill dealing with tax credits for families that maintain a household with an elderly dependent.

As you know, and as you indicated, earlier this year I introduced S. 1581, a bill which is very similar to the tax credit provision in your legislation. You will also recall that the idea of providing tax credits for this type of care was originally proposed as part of the Family Protection Act of 1981, of which you are a cosponsor.

The major difference between our approaches is that the Jepsen bill offers the taxpayer the option of a tax deduction of \$1,000 or a tax credit of \$250. Your bill, on the other hand, offers a \$500 tax credit.

Whether we use tax credits, tax deductions, or some combination of the two to recognize the importance of keeping the elderly

person in the home is not the issue. What we must focus our attention on is the great benefit that can be derived from this type of multigenerational or three-generational living arrangement.

For too long, Government programs such as medicare, medicaid, and others have been effectively encouraging families to institutionalize their loved older ones. I do not believe this was the intent of these programs. In fact, most of them were extremely well-intended. Unfortunately, when these programs were devised, they examined the elderly population in individual terms rather than family terms.

It is only by recognizing the important relationship between the elderly and their family that coherent and socially useful policies can be developed. Only then can appropriation and consistent programs relating to the elderly and their families be made. I believe the Hatch and Jepsen proposals attempt to recognize this need.

Fortunately, Mr. Chairman, the decision to seek long-term care or institutionalization for an elderly loved one is not a decision faced by most families. However, for those who do consider it, the decision is very difficult and often very agonizing.

Studies have shown what most of us knew in our hearts to be true, that is that most families would prefer to keep elderly family members at home, and most elderly individuals would prefer to live in a family atmosphere as opposed to a nursing home.

In order to understand why the tax credit/tax deduction idea is important, we must understand what factors are involved when families make that decision to seek institutionalization as an answer.

According to George Maddox, director of the Center for the Study of Aging and Human Development at Duke University, there are a number of important considerations that go into the decision to seek institutionalization. They are: One, the degree of impairment; two, availability of family members to provide care; three, availability of living space; four, perceived danger to elderly individual; and, five, the economic cost of alternative arrangements.

Additional research shows that, of these, the two most important appear to be availability of family and availability of money. Fortunately, there is something we can do about the availability of money.

As I mentioned earlier, there is almost a federally mandated bias towards institutionalization. The Federal Government provides assistance to families if they want to place an elderly family member in a nursing home. In contrast, it provides very little assistance for families who want to keep the family member at home. In addition, low cost Federal loans are available for the construction of nursing homes, but little assistance is available for in-home care.

All of this has the practical effect of drastically increasing the relative economic cost of any alternative to a nursing home, particularly home care. Instead of removing the economic disincentive towards keeping the elderly person in the home, the Federal Government has been providing an economic incentive to institutionalize the elderly.

I would like to close, Mr. Chairman, with a story that I heard recently which puts the whole issue in perspective. I hope it makes everyone else think about this issue the way it has me.

There was a family that was very prim and proper. Their house was always neat, everything in place, and always the best that money could buy. It seems that the mother of the woman of the house was becoming quite old, and it became necessary for her to move in with the family. Things were not working out too well because the older woman did not always put things away and had a tendency to drop things.

One night at dinner, while passing her plate, the older woman dropped the plate and it broke. Needless to say, her daughter was outraged because this was some of her fine china. After dinner, the younger woman told her son to go down to the local market and buy a tinplate. When he asked what it was for, he was told it would be used by his grandmother so she could not break any more of the fine china.

When the little boy returned from the market, his mother discovered that he had bought two tinplates, not just one. She proceeded to ask him why he had bought two and not just one. He answered, "The other tinplate is for you, Mom, when you get old."

The moral of this story, Mr. Chairman, is quite simple. Treat your parents as you would have your children treat you.

I believe you have an excellent piece of legislation, Mr. Chairman. I look forward to working with you to seek its adoption.

The CHAIRMAN. Thank you so much, Senator Jepsen. We appreciate you taking time to come over and enlighten our committee this morning.

The remainder of this hearing will be devoted to two panels, both of which rifle in on the specific policy questions which have been and are being raised about home health care services and S. 234 in particular.

In the best interest of time in order to cover all of the remaining ground, we have had to limit the number of witnesses and have asked each of them to honor the 10-minute rule in presenting their oral testimony. I realize that Senators are in no position to be self-righteous when it comes to energy conservation in public speaking, but that is another reason why you are here today, to set a good example for us up here.

I should emphasize how sincerely I regret not having had all the hearing time I would otherwise have wanted in order to hear all the experts and organizations requesting to testify here today. After discussions with my committee colleagues, I invited what I believe are a representative sampling of both providers and experts to participate in the following two panels.

I will also keep this hearing record open for 10 additional days in order to receive any written testimony others may wish to have included as part of the final printed report which will be used as the basis of any legislative action following today's session.

I ask that all members of the first panel come to the hearing table. The first panel will focus on reimbursement and reporting issues because each of the witnesses on the panel represents different organizations or affiliations and perhaps share different points of view. That is to say I do not think they have really had a chance

to meet one another, much less rehearse. I am asking that each witness be open to any questions by members of this committee immediately after their respective opening remarks.

Let us begin with our first team of witnesses: Dr. Philip W. Brickner and Dr. Anthony Lechich, directors of the Department of Community Medicine at St. Vincent's Hospital in New York City, known to the readers of Newsweek magazine as the leaders of the Chelsea Village Program mentioned by Miss Hayes in her remarks.

This is a return performance for both of you, noting your involvement in our first hearing on S. 234 last March. I thank you for coming once again. I also understand that in your presentation today you are also representing the Catholic Health Association of the United States. We are delighted to have both of you with us today. We will begin with you, Dr. Brickner, and then you, Dr. Lechich. Then we will introduce the others.

STATEMENT OF PHILIP W. BRICKNER, M.D., DEPARTMENT OF COMMUNITY MEDICINE, ST. VINCENT'S HOSPITAL, NEW YORK, ACCOMPANIED BY ANTHONY LECHICH, M.D.; LINDA KEEN SCHARER, ASSISTANT DIRECTOR; KATHRYN M. ZUNICH, M.D., RESIDENT PHYSICIAN; AND ROBBIE LIPSMAN, EXECUTIVE DIRECTOR, PRIDE LONG-TERM HOME HEALTH CARE INSTITUTE, ST. VINCENT'S HOSPITAL

Dr. BRICKNER. Thank you, Senator.

I will make our remarks as brief as possible, as pungent as possible, and as fact filled as possible. Since we have prepared written testimony, Senator, I request permission on your part to accept our written testimony for the permanent record of this committee hearing.

The CHAIRMAN. Without objection, all prepared statements will be placed in the record at the appropriate places.

Dr. BRICKNER. I would like to take a moment to introduce three colleagues from St. Vincent's Hospital whom we brought with us and who will be prepared to answer questions should they be addressed to us after our testimony: Dr. Kathryn Zurich, a young resident physician in our department of community medicine at St. Vincent's; Robbie Lipsman, director of the PRIDE Long-Term Home Health Care Institute of St. Vincent's Hospital; and Linda Scharer, assistant director of our department of community medicine.

The CHAIRMAN. We are happy to have you here.

Dr. BRICKNER. Our basic point, Senator, is to have all of us recognize the need for the development of national policy in the field of long-term home health care. We wish to point out first of all that older people in many parts of the United States have chronic care needs which cannot be met under present regulations.

Let us remember in this discussion that we are talking about home health care, not simply home care. Our concerns regarding legislation have to be broad enough to recognize that health issues are immediately relevant to the needs of frail older people, that important as nonprofessional assistance in the home may be, it is not enough.

Second, we have grown to understand that acute care hospitals now house significant numbers of older people awaiting placement

in chronic care facilities such as nursing homes. Further, and as has been pointed out, money flows now toward institutional care rather than toward care at home for older people. Yet we are beginning to recognize that there is no room at the nursing home.

Fourth, this problem is growing. What people have called a demographic imperative is upon us, because of the increasing numbers of older people who will be living with us. During the next 20 years the present systems for care of frail older people will be overwhelmed. It is time to recognize the need for additional chronic care resources.

With your permission, Senator, I would like to go to this blackboard for one moment in order to attempt to make clear what we are discussing.

The CHAIRMAN. Certainly.

Dr. BRICKNER. My apologies to those of you who may have seen this material described before. This is a bell-shaped curve designed to represent the random distribution of 80-year-old people in this country. At this end we have superb 80-year-olds who in their advanced age are far more efficient and brilliant than any of us will ever be. We have had three superb examples in this room this morning: Congressman Pepper, Senator Randolph, and Helen Hayes.

Next, there is a large group of older people who are entirely competent to take care of themselves and do not need any particular form of assistance.

Then we move toward the group of older people who do in fact need some help. This is where assistance can be provided by many community-based programs now in existence: homemaker programs, visiting nurse associations, et cetera. They are entirely competent and very effective in giving moderately complex forms of help which enable older people to survive it safely at home.

Now we get to the frailest older people. As you know, about 5 percent of people over age 65 in this country live in chronic care beds, and about 9.5 percent of people over age 75 live in such beds.

I ask you to consider for one moment what is going to happen to the nursing home stock by the year 2000 when the numbers of older people, the raw numbers, will have increased very significantly. It is our view that this relatively small proportion of people of greatly advanced age and frailty, the last portion represented within the bell-shaped curve, are the people upon whom this form of legislation should concentrate. It is why we feel so strongly that hospitals must be included among the agencies permitted, and in fact encouraged, to carry out comprehensive long-term home health care programs.

With your permission, Senator, I will resume my seat. Unless a broad national policy is established supporting long-term home health care for the aged, there will be a necessity virtually to double the number of chronic care beds now in existence by the year 2000, with the associated confusion, cost, waste, pain, and further warehousing in inadequate circumstances of older people.

This bricks and mortar approach, in our view, is a bankrupt approach. It is heartless. Helping older people remain home is more appropriate in the interests of the country at large and of the individuals concerned alike. In fact, we should view institutional

placement as the alternative, and staying at home as the logical and appropriate standard for older people.

A brief comment about our work at St. Vincent's Hospital: For almost 9 years we have given long-term home health care services to people living in Chelsea and Greenwich Village in Manhattan. We have experience with slightly more than 1,000 people. We have established, at least to our own satisfaction, that hospital based care at home is a viable idea, that it is cost effective, and it helps older people remain independent and out of institutions, meeting often their own desperate wishes.

One purpose of your legislation, S. 234, is, to encourage the establishment of home health programs. As I noted a moment ago, we urge especially that hospitals be encouraged to carry out these programs.

I wish to point out that in our view, Senator, for the most frail patients, that is those who have serious medical and social problems intermixed, hospitals are most likely to have available the necessary skilled staff members, including physicians, to carry out viable programs. It is these patients who are most likely to be forced into nursing homes or to die unattended in their own homes. It is these people who most need the doctor, nurse, social worker team in order to fulfill their urgent desires to remain independent and at home. It is for this group that the legislation under discussion today will be most valuable.

We recognize that all agencies involved in providing long-term home health care, including hospitals, must achieve an acceptable form of certification. We urge the committee to recognize that hospitals which are permitted under section 1866 of medicare law to care for patients have already passed through an ample and appropriate certification process. We feel that this process is sufficient to entitle hospitals to conduct such programs in the homes of patients. Any additional certification process imposed upon hospitals will be redundant, expensive, and have a freezing effect on the necessary expansion of hospital based long-term home health care.

Before I turn to Tony Lechich to continue our brief testimony, I want to point out some concerns about cost. There is of course proper concern on all of our parts about costs and about the possibility of fraud and abuse. We have to deal with these concerns if we are to move forward.

First of all, without a broad national policy on long-term home health care, we will continue to face fragmentation of services with multiple agencies involved in the care of patients, waste of money, and the concurrent problems of excessive use of medications, supplies, and duplication of services.

Second, without such a program in place, there will continue to be overreliance on emergency care. It speaks for itself that without an organized plan for care at home, the emergency room is the common resource for people who have become desperate, usually a resource imposed too late or in an inappropriate and wasteful fashion.

Then there is the question of hospital overstay. In New York State, as well as in other States around the country, there are growing delays in the movement of patients from hospitals to nursing homes. The result is a backup in acute care beds at a high

cost to the public since most patients awaiting placement are covered by public reimbursement.

Our own analysis reveals after discussion with people in other States as well as in New York that reported average hospital overstay in New York State have reached the length of 36 days, in Connecticut over 46-days delay for the average patient waiting to get out of an acute care bed, and in Massachusetts almost 8 days. These are patients already approved for nursing home transfer who are clearly nursing home candidates.

Then there is the matter of overreliance on acute care beds. As we explained in our earlier testimony before you, Senator, we were initially drawn to the problems of the homebound elderly from our experiences in our own hospital. It was our belief that home health care could relieve a reliance on acute medical care in hospitals. Our belief has been borne out by our experiences.

Studies of our own Chelsea Village program patients reveal that for those people who are active in the program for a full 2 years there is a significant decrease in the need for hospitalization during the second 12-month period compared to the first 12-month period. This satisfies us that it is possible to stabilize older people in their own homes and that the need to fall back on acute care beds decreases when patients are involved in an effective program.

Last, a comment about the use of informal support services. There is great concern that the expansion of home health care services will discourage family and friends from providing help informally, thereby increasing unnecessarily the public burden. Our experience and information from other programs shows that this is simply not true. Family and friends are often scared away when the needs of a homebound aged person begin to multiply.

Our staff have succeeded in providing reassurance to these informal care givers. In some cases, family members who allowed themselves to become lost have become reinvolved after the introduction of our services. In fact, in the Chelsea Village program, although two-thirds of our patients live by themselves, most are in touch with a family member or close friend. They are not truly abandoned.

A sampling of home-care patients in Minnesota, for instance, indicates involvement of a family member or friend in more than three-quarters of the cases. Therefore, providing comprehensive home health care does not discourage the involvement of informal care givers. Quite conversely, the involvement of a home health provider can encourage family members and friends to get involved.

I lastly wish to point out, Senator, that any cost analysis must recognize as well the cost of not taking action. Unless a comprehensive proposal is put into place, such as is represented by your bill, we are going to be faced with a totally chaotic situation in the next 20 years.

I will now ask Tony Lechich to continue our testimony.

Dr. LECHICH. I would like to thank the committee for the opportunity to testify today and I guess our founding fathers for the privilege.

In addressing the committee's concerns about fraud and abuse, we wish to note that we are not experts in regulation or cost

control. Our comments are based on 9 years of hands-on experience in working with the homebound aged in a hospital based free program—that is how it started—and then more recently in a State subsidized medicaid program with a capitation payment mechanism.

When the program was free, supported by the hospital and private philanthropy, we helped as many people as we could. That was our mission. Abuse here would have been doing too little and with poor quality. For example, if a nurse spent too much time on patient A, it would detract from patient B, and we only had one nurse to go around. Abusing and defrauding third party payers was not possible because there were none. As this utopia could not sustain itself, money had to flow in if it were to continue.

In March, in response to the observation that there is a natural escalation of costs seen with a fee for services reimbursement mechanism, we recommended consideration be given to a capitation grant system for long-term health care. To a certain extent, the New York State Lombardi programs function under this system with an average cost limitation of about \$1,500 a month per patient, which is 75 percent of the nursing home rate in our district.

The capitation arrangement quite naturally creates a competition for services, and with a well-administered program, the right service would be delivered over a lower priority service because everyone in the program understands that per case there is just so much money to go so far.

Other professionals have agreed that the capitation grants make good sense. Still others recommended adopting the HMO concept. While the capitation grants limit the extent of the public's financial liabilities, they create the potential also for the misuse of funds within that system by specifically undertreating patients and treating the wrong patients.

We see proper patient selection as absolutely vital to this function. Simply stated, if you choose the right patients, then they deserve the \$1,500. This brings us to the assessment difficulties as mentioned and studied elegantly by the GAO which are causing us so much trouble.

Verification of services preferably by impartial observers would also be necessary. The assessment, as we saw it, really does require referees. It requires participation by many different disciplines, particularly those assessing social service needs, which was stressed by many of the researchers as being a deficiency in previous assessment mechanisms.

As Miss Hayes alluded to, a patient who lives on top of 39 steps would be needing assistance because of these 39 steps. Here congestive heart failure and perhaps even incontinence would take a second position under the first "soft" need. It is up to the individual programs and how they are administered to very carefully select which patients need what; to tailor the services to the need. That is far from solved.

It should also be recognized that a patient's needs sometimes diminish, particularly following the resolution of acute setbacks. There should be provision for a flow between greater and lesser dependency and provider responsibilities. For example, patients in nursing homes should be considered for discharge back into the

community if they have gotten better or if some other remediable condition has changed. This is essential. Incentives to that end ought to be included.

The fee for services rendered method seems to be the least popular and most encouraging of abuse. Third party fiscal intermediaries may also be a potential weak spot, both need further study.

I think special emphasis ought to be made of the value of a homemaker in the total patient plan. Homemakers account for the majority of expenditures on our budget. It is the homemaker that makes the difference. The homemaker is often the patient's only attachment to the world on a regular basis, especially for very isolated patients.

However, our studies show that in an analysis of a sample case-load of 102 patients, only 63 needed a homemaker at all. These are sick patients. These are patients, 39 of whom were skilled nursing facility eligible and another 30 percent were, health related facility eligible. Only one-fourth—16 of 102—required half or full-time help; 75 percent of the patients received less than half time care. This is cost effective but only if they are chosen for the right people. Therefore, homemakers and research in their utilization must be targeted in any scheme to assist the elderly.

Another form of abuse arises in family responsibility. What constitutes selfless duty on the part of one family is truly undue hardship for others. I recall a case of a 90-year-old French gentleman who lived in a welfare hotel with his daughter. On a visit you would walk in and there stood a hospital bed in the middle of a studio apartment with Pampers boxes, catheter equipment and all kinds of supportive equipment in the room. The woman who took care of him was his daughter. Nothing was a chore for her. She was willing to take on all problems. The man died at home with her at his side, which I should point out is a very cost effective thing. Other families react differently and reach out earlier.

In our experience, families can and will come into the scene when called upon. They can also advocate. In a services capitation type arrangement they will ask us for the most essential services, which perhaps is the best guide.

I would like to add also the need to encourage volunteerism. Senator Randolph alluded to voluntarism. The hospice program is perhaps the shining example of volunteerism in the country. Volunteerism will go far in keeping the spirit of these programs in the right place and offset potential abuse.

I support the hospitals as being very important loci for these programs for the reasons already cited. We believe that it can be done. A lot of the above disclaimers are troublesome, but the work must go forward also for the reasons cited.

In conclusion, I suppose all who come before the committee make compassionate pleas for their causes, each telling of the monumental importance of their issues. No single piece of legislation was ever without problems in implementation or without necessary regulations.

We feel that the Community Health Services Act of 1981 strikes at the heart of the most fundamental of problems, that of caring for those helpless and those most in need. It remains as usual for

you and us to judge in our own hearts and minds, and perhaps for our parents, how important this really is.

Thank you again for this opportunity.

The CHAIRMAN. Thank you. Both of you have been some of my great inspiration as I have watched what you have done in your Chelsea experience. The good work you have been able to do will go a long way toward helping this bill to pass. We hope that will be during this Congress.

I have a number of questions I would like to ask you, but I am only going to ask one and then submit the rest in writing.

As you know, I have substantially added provisions to S. 234 following last March 4's hearing. One of these provisions was increasing the level of participation. The question that continually comes up is in the form of asking why nonprofit certified hospital based home health care programs like your own at St. Vincent's Hospital should be able to receive reimbursement for services under medicare and medicaid when these programs are not certified home health care agencies. That is, should these programs be permitted to be eligible for reimbursement on an equal footing with those programs that are certified? Is it fair? Is it workable? Would you mind commenting on this and perhaps draw from your own experience with the Chelsea Village program?

Dr. BRICKNER. In discussing the question of equity, Senator, between various sorts of home health providers, we are concerned basically with benefitting the providers rather than caring for the needs of the patients.

We are all entitled, of course, to take pride in what we do and to have concern about our own viability. However, in a setting such as this legislative hearing where we have the great privilege of addressing national need, the relatively small differences between the concerns of the various providers should be set aside in the interests of trying to understand what is best for the broader population and the people who are to receive the services.

Therefore, to answer your question specifically, I think the issue of what form of certification each sort of provider is going to receive is not particularly important. As I attempted to make clear in my testimony a few moments ago, Senator, all hospitals who take care of medicare patients as inpatients have already received a certification by the Federal Government and, in fact, have gone through an onerous process to receive that certification.

In our view, to add yet another form of certification to approve these hospitals as home health care providers would be unnecessary, expensive, and have a freezing effect on the hospitals themselves. In fact there is a national need to encourage hospitals to develop programs of this nature. Therefore, any action which can be taken to encourage hospitals to develop such programs at cost, not at a profit, should be pursued. Any action which will tend to discourage hospitals, such as redundant and excessive certification processes, should be barred.

[The prepared statement of Mr. Brickner and responses by the panel to Senator Hatch's questions follow:]

Testimony Prepared for Hearing Before
Committee on Labor and Human Resources

on

S.234

Community Home Health Care Services Act of 1981

Senator Orrin Hatch

November 10, 1981

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Research and analysis by the PRIDE Long-Term Home Health Care
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INTRODUCTION

In 1981, older people in many parts of the United States have chronic care needs which cannot be met. Long-term beds are full. Acute care hospitals now house significant numbers of older people awaiting placement at substantial dollar costs (1,2,3), and the problem is growing.

We are here today to discuss this problem and the merits of the Community Home Health Services Act of 1981, a measure which we feel addresses this critical health care need. Our experience as physicians has shown us that home health care can effectively respond to the long-term care needs of many elderly people in a viable and cost-effective manner. In March 1981, we had the privilege of sharing with you our enthusiasm for long-term home health care, based on the experiences of our Chelsea-Village Program of St. Vincent's Hospital in New York City. Our purpose today is to illustrate more rigorously why we support home health services as a national prescription for long-term care needs.

THE SCENARIO

Home care is not a new phenomenon. It is important to understand that for many decades medical professionals have been administering care in people's homes. As Senator Quayle pointed out earlier this year (4), visiting

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nurse services date from the turn of the century. Even modern home care is over thirty years old, dating back to Montefiore Hospital's first endeavor in 1948. Our Chelsea-Village Program is in its ninth year.

The demographic projections for the United States population aged 65 and over are staggering. In the next 20 years this population will double and by the year 2030 there will be over 55 million people aged 65 or over residing in the United States. The group of elderly 85 years old or more will triple by that year (1,4,5).

The impact of these projections can best be understood if we take a look at some of the recent trends in long-term care services and needs. It is estimated that perhaps as many as one million people need long-term care services but do not receive them (1). A recent study issued by the Federal Council on the Aging illustrated the impact of this problem for the elderly. According to their research, 1% of all people under age 45 are unable to carry on major activity due to chronic conditions. For those 45 to 65 years of age, it is 6%. The proportions continue to increase significantly with age, as can be seen from the numbers below:

AGE GROUP	PERCENT UNABLE TO CARRY ON MAJOR ACTIVITY
65-74 years	14
75-84 years	20
85 and over	31

3.

While lack of available care affects every age group, it is clearly a more critical issue for the more aged groups in our population.

Past trends indicate that the traditional solution for long-term care has been a reliance on institutionalization. In the past, over 90% of the public cost for long-term care has gone to nursing homes. In 1979 the total cost for nursing home care was \$17.8 billion. Nine out of ten residents in nursing homes were over 65 years of age (1).

Though the numbers document a continued use of institutional care, increasing numbers of people are receiving home health services. In 1979, 836,700 persons were served by home health agencies. Less than 500,000 people received such services in 1975 (6). Home health expenditures, nevertheless, represented only 2% of the total Medicare budget in 1978, and only 1% of all Medicaid costs for that same year (1).

The numbers clearly illustrate our dilemma. We do not have the dollars to continue to support this pattern of care. And now we must prepare for an even greater demand on the system. The situation was aptly summed up in a report on long-term care prepared by HCFA earlier this year. We would like to quote directly from that document:

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The proportion of the population that is aged will rise significantly over the next fifty years. As a result the need for long-term care services will increase enormously. Because the growth in the elderly population will outstrip that of the working population, the strain on public programs will be enormous. (1)

A RATIONALE FOR HOSPITAL-BASED HOME HEALTH CARE

In our view it is essential that hospitals be included among the agencies permitted to create and carry out LTHHC programs for the home-bound aged. For the most frail patients, those who have serious medical and social problems inter-mixed, hospitals are most likely to have available the necessary skilled staff members, including physicians, to carry out viable programs. It is these patients that are most likely to be forced into nursing homes or to die unattended in their own homes. It is this group of people who most need the doctor-nurse-social worker team, in order to meet their desperate wishes to remain independent at home; and it is for this group that the legislation under discussion today will be most valuable.

We recognize that all agencies involved in giving LTHHC, including hospitals, must achieve an acceptable form of certification. We urge the committee to recognize that hospitals which are permitted under Section 1866 of Medicare law to care for patients have passed through an ample and appropriate

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certification process, sufficient to entitle them to conduct such programs in the homes of patients.

In our testimony in March we noted two important reasons to support extended use of home health care. We explained the human factors and tried to illustrate how important the choice to live out one's life at home was to our patients. We also compared the costs of the Chelsea-Village Program and nursing home care in New York City. We noted that, in our experience with our 1,000 homebound aged patients, long-term care at home costs approximately 60% of the cost for institutional care (4,7,8).

Particular concerns about the potential costs of LTHHC and the possibility of fraud and abuse must be addressed, if this discussion is to move forward.

Cost Control

There are five cost factors which we would like to discuss today in order to explain more fully the basis for our belief that home health care is cost-effective. These issues have become apparent in our own work as well as through our conversations with other health professionals.

These factors are:

1. Fragmentation of services
2. Over-reliance on emergency room care
3. Hospital overstay
4. Over-reliance on acute medical care
5. Use of informal support services

Fragmentation of Services

The uncoordinated involvement of multiple agencies in the care of a patient can be costly. It is also an inefficient use of limited resources. We have experienced such situations, particularly when first admitting a patient to our long-term home health care program.

Until coordination was completely worked out, patients often received double medication, supplies, and duplicate services from social workers or other professionals. Service coordination in home health care can reduce this waste.

Over-reliance on Emergency Room Care

For many isolated elderly people the local hospital emergency room is a logical source of support when the disabilities created by a chronic disease become overwhelming. Relying on hospital emergency care, however, is not an efficient use of health care resources. We have dealt with this problem with our own patients, as

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illustrated in the following care report:

F.P. is an 89-year-old man, living alone, known to the program two years. Shortly prior to our intervention, he had been hospitalized twice for generalized weakness, dyspnea, and malnourishment. He insisted upon returning home when he improved.

A neighbor referred the patient to us at a point when the process of deterioration was starting again.

Medical evaluation showed that Mr. P. had emphysema and chronic bronchitis with limited exercise tolerance, sufficient only to care for himself at a minimal level. In discussions with a social worker and nurse, Mr. P. made it clear that he was depressed, because he was alone and afraid of death. During the first few months of our relationship, he called the ambulance eight times and was brought to the hospital emergency room in a state of panic, but with reassurance that he was not dying, he was willing to go back home.

Our doctors established medical treatment of his lung disease. Through regular visits, the nurse helped Mr. P. plan a method of remembering the proper doses and intervals of his medications. The social worker spent time talking with Mr. P. about his fears. She also obtained a homemaker who was willing to work at night, the time of greatest anxiety, and who prepared a substantial dinner, kept the apartment clean, and did necessary shopping.

This combination of practical service, control of disease and personal attention has been effective in keeping Mr. P. comfortable and cheerful in his own home. Over the last 22 months, there have been no hospitalizations or ambulance calls.

Hospital Overstay

In New York State, as well as in other states around the country, there are growing delays in the movement of patients from hospitals to nursing homes. The result is a back-up in acute care beds, at a high cost to the public

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since most patients awaiting placement are covered by public reimbursement (1). This is costly and inefficient.

For example, studies undertaken in New York, Connecticut, and Massachusetts reported average hospital overstays of 36 days, 46.7 days and 7.75 days respectively (2,9,10) for patients already approved for nursing home transfer. A one-day survey on hospitals completed in March 1980 for Vermont revealed an average of 85 patients awaiting placement(11), while the September 1980 "Long Term Care One-Day Census" of the American Association of PSROs, identified 17,783 Medicare and Medicaid patients awaiting placement (3).

The methodologies and dates of these studies have not been compared, so the numbers can only be considered informally. This back-up in acute care facilities is a broad concern. The costs are enormous and yet hospitals have no alternative in most communities, if nursing home beds are not available. Expanded home health services could begin to address this problem.

Over-reliance on Acute Medical Care

As we explained in March, we were initially drawn to the problems of the homebound elderly from our experiences in the hospital. It was our belief that home health care

could relieve a reliance on acute medical care. Our belief has been borne out by our experiences.

Studies of Chelsea-Village Program patients reveals a declining use of acute care beds after completion of one year in the program. New patients spend an average of 6% of their Chelsea-Village Program time in the hospital. Those in the program one year or more spend only 3.8% of their CVP time hospitalized (12). In addition, the mean number of visits required from the CVP team decreased from 16 to 17 visits during the first year, to 10 to 11 visits after one year (12).

Home health care can not only prevent unnecessary hospitalization, but it can also shorten the length of stay when hospitalization is required (14). The CVP team stays with a patient throughout hospitalization. Discharge back to the program and the patient's home is easily facilitated.

Use of Informal Support Services

There is great concern that the expansion of home health care services will discourage family and friends from providing services informally, thereby increasing unnecessarily the public burden. Our experience and the data from other programs shows that this simply is not true.

Family and friends are often scared away when the needs of a homebound elderly person begin to multiply. Our staff have provided a reassurance to these informal care givers. In some cases, lost family members have become re-involved after the introduction of our services. In the Chelsea-Village Program, 83.5% of the patients receive assistance from a relative or friend (12). A sampling of home care patients in Minnesota indicates involvement of a family member or friend for 78% of the cases (15). Providing comprehensive home health care does not discourage the involvement of informal care givers. Quite conversely, the involvement of a home health provider can encourage family members and friends to become involved.

Fraud and Abuse

In addressing the Committee's concerns about fraud and abuse we wish to note that we are not experts in regulation or cost control. Our comments are based on nine years of hands-on experience in working with the homebound aged.

Limiting the Liability: Capitation

In March we recommended consideration be given to a capitation grant system for long-term health care. To a certain extent the New York State Lombardi programs function under this system, with an average cost limitation

11.

of about \$1500 per month per patient. Capitation grants are an incentive to spare patients excessive and inappropriate services (4). Other professionals have agreed that capitation grants "make good sense" (16). Through capitation, agencies are encouraged to use the least expensive service, as long as quality care is maintained.

Controlling Fraud and Abuse

While capitation grants limit the extent of the public's financial liabilities, they create the potential for misuse of funds within that system by under-treating patients. Another funding approach -- fee for services rendered -- encourages liberal attention to patients at the risk of over-use, and wastage of money. Past experience has shown that the functions of the fiscal intermediary may be a potential weak spot. Further consideration of proper payment mechanisms is necessary, perhaps with trials of several methods.

We are well aware of the value that the homemaker has in the total patient plan. That person is often the patient's only attachment to the world on a regular basis. Our studies, however, show that in a case load of 102 patients, only 63 need a homemaker or home attendant. Of these 63 patients, only one-fourth require half- to full-time help, 75% of the patients receive less than half-time care (12).

These experiences help us plan an efficient use of our resources and may prove useful in establishing broad comprehensive guidelines. The efficient use of resources, however, is dependent on sound gatekeeping mechanisms. Inappropriate enrollment of people for whom involvement would be a luxury, not a necessity, must be controlled. We also encourage the development of systems for withdrawing services when no longer appropriate. We realize, however, that they are only our experiences, and may not be realistic measures for a national program.

We believe that reasonable control of costs and abuse can be achieved. The overall funding for the program as well as the regulations governing assessment and provision of care must be developed in a manner which minimizes the opportunity for waste and fraud by unscrupulous institutions and staff members.

CONCLUSIONS

The scenario is clear. Our population is growing older, and with that shift, the number of persons disabled by chronic illness will increase. The services currently available are stretched beyond their limits and continued growth along the same avenues is financially unacceptable. The situation can best be summarized as follows:

13.

The option of Medicaid reform, while important, is limited by financial eligibility restrictions and therefore cannot be sufficiently broad to cover the needs of the population at risk. Medicare law does not permit hospitals to bill for services rendered by paid staff members outside institutional walls in a manner appropriate to the long-term requirements of homebound isolated aged people. Standard hospital home health agencies, which are permitted reimbursement, are geared to post-hospital care and lack authority to sustain patients over time. These nursing-oriented programs generally do not include physicians and social workers as integral staff components. Thus, the requisite skill and team effort for effective care at home, for aged people with complex and chronic care needs, are lacking. (7)

The necessary revision of Medicare regulations, as drawn in the Community Home Health Services Act of 1981, will remedy this problem.

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3. American Association of Professional Standards Review Organizations: Long-Term Care One-Day Census. September 1980
4. Hearing Before the Committee on Labor and Human Resources, United States Senate, Ninety-Seventh Congress, First Session on S.234, Community Home Health Services Act of 1981, March 4, 1981. U.S. Government Printing Office, Washington DC, 1981
5. Federal Council on Aging: The Need for Long-Term Care: Information and Issues. U.S. Department of Health and Human Services, Office of Human Development Services, Washington DC, 1981
6. Division of Information Analysis, Health Care Financing Administration: Preliminary Data - Use of Home Health Services, 1979. U.S. Dept. of Health and Human Services, Washington DC
7. Brickner PW, Scharer LK, Lechich AJ, Duque T, Quirke E, Ruether B, Harnett E, Starita L: A strategy for reducing emergency room needs for the frail aged. Publishing pending
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9. Connecticut Hospital Association: Extended Hospital Stays: Current Status of the Problem. September 1980
10. Massachusetts Hospital Association: Report on Patients in Massachusetts Hospitals Awaiting Placement into Long-Term Care. October 1979

11. Vermont Hospital Association: Summary of Data for Second ECF Patient Survey. June 1980
12. Varon J: Implementing Long-Term Home Health Care. A report submitted to the Florence V. Burden Foundation by the Department of Community Medicine, St. Vincent's Hospital. New York, October 1979
13. Varon J, Scharer LK, Brickner PW: Home Health Care at St. Vincent's Hospital and Medical Center of New York, 1978-80. A report to the Florence V. Burden Foundation, New York, April 1981
14. North Carolina State Health Planning and Development Agency: Hospital Discharge Study. October 1978
15. Anderson NN, Patten SK, Greenberg JN: A Comparison of Home Care and Nursing Home Care for Older Persons in Minnesota. Hubert H. Humphrey Institute of Public Affairs and Center for Health Services Research, Univ. of Minnesota, Minneapolis, June 1980
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QUESTIONS FOR DR. BRICKNER AND DR. LECHICH

- 1) WHY DO YOU FEEL AS STRONGLY AS YOU APPARENTLY DO, THAT THESE PROGRAMS OUGHT TO BE HOSPITAL BASED, THAT IF PREFERENCES RULED SUPREME, THEY WOULD NOT BE BASED IN A VARIETY OF SETTINGS, INCLUDING THOSE THAT ARE NOT BASED IN HOSPITALS?
- 2) AS YOU KNOW, I HAVE SUBSTANTIALLY ADDED PROVISIONS TO S. 234 FOLLOWING LAST MARCH 4TH'S HEARING, ONE OF THESE PROVISIONS INCREASING THE LEVEL OF PARTICIPATION. A QUESTION WHICH CONTINUALLY COMES UP IS IN THE FORM OF ASKING WHY NON-PROFIT CERTIFIED HOSPITAL-BASED HOME HEALTH CARE PROGRAMS, LIKE YOU OWN AT ST. VINCENT'S HOSPITAL, SHOULD BE ABLE TO RECEIVE REIMBURSEMENT FOR SERVICES UNDER MEDICARE AND MEDICAID WHEN THESE PROGRAMS ARE NOT CERTIFIED HOME HEALTH CARE AGENCIES. THAT IS, SHOULD THESE PROGRAMS BE PERMITTED TO BE ELIGIBLE FOR REIMBURSEMENT ON AN-EQUAL-FOOTING WITH THOSE PROGRAMS THAT ARE CERTIFIED? IS IT FAIR? IS IT WORKABLE? COULD YOU COMMENT ON THIS, AND PERHAPS DRAW ON YOUR OWN EXPERIENCE WITH THE CHELSEA VILLAGE PROGRAM?
- 3) COULD YOU EXPAND A LITTLE FURTHER ON HOW IT IS YOU FEEL HOSPITALS WILL REACT TO THIS LEGISLATION WHEN IT IS ENACTED? WHAT DO YOU ESTIMATE DOCTORS' RESPONSES WILL BE TOWARD PARTICIPATION IN IT, AND HOW WILL HOSPITALS FEEL ABOUT STARTING THEM?

QUESTIONS FOR DR. BRICKNER & DR. LECHICH, CONT'D

- 4) EMERGENCY ROOMS AND CLINICS ARE BROADLY MISUSED BECAUSE DOCTORS ARE SAID NOT TO MAKE HOUSE CALLS. TELL ME DOCTORS, HOW DO YOU SEE THIS BILL CORRECTING THIS PROBLEM?
- 5) WE HEAR A LOT ABOUT THE DEFICIENCIES IN GERIATRIC EDUCATION AND INSENSITIVE MEDICAL TRAINING. BASICALLY, HOW WILL PASSAGE OF THIS BILL IMPROVE THE DOCTORS EDUCATION?
- 6) HOW WILL THE DEVELOPMENT OF THESE PROGRAMS IMPACT ON THE HOSPITAL STAFF?
- 7) WHAT DO PATIENTS THINK ABOUT THIS PROGRAM?

RESPONDER: Linda K. Scharer

1. Hospital-based programs are most likely to be able to provide the necessary choice of resources which the frail elderly require, while maintaining continuity of care with each individual. The hospital-based program acts as the patient ombudsman. Each patient is assigned to a physician, nurse, and social worker. In this setting, team members can easily arrange care from such often used subspecialties as ophthalmology, psychiatry, orthopedics or rehabilitative medicine. In many cases these sub-specialty physicians visit the patient at home. Should hospitalization be required, the team provides continuity of care while at the same time promoting the opportunity for the patient to return home to a setting all ready known to members of the staff.

Question #3 RESPONDER: Anthony Lechich, M.D.

Despite recent amendments, reimbursement to hospitals is still focused on acute illness. There is simply inadequate provision for long term care for the chronically ill aged. Hospitals are now faced with many patients awaiting placement in skilled nursing homes or health related facilities. These are patient who would often be able to return home if more comprehensive programs were available. The Community Health Services Act of 1981 will address this.

Hospital administrators will want to know how a home program can fit their hospital budget and community needs. They will want to explore existing programs, and provision for this will be needed. There may be instances where new suitable models will have to be developed, as all hospitals and their communities throughout the United States are not homogeneous.

Both attending physicians as ourselves, and trainee physicians have been personally and professionally enriched by the opportunity to serve in the Chelsea Village Program. We are certain that this will follow in other institutions. In our experience, many graduating residents have chosen to continue serving the program despite busy private practice demands.

This program also addresses the widely recognized deficiency in geriatric training in the United States. What better laboratory for the study of geriatrics than the elderly patients home?

Since the beginning of our experience with the Chelsea Village Program, we have received many visitors from other hospitals. Some have wished to start their own program in response to community pressure, but most have simply cared to address their own observations of the many chronically ill aged patients arriving in their clinics and emergency rooms in a state of neglect.

The enactment of S.234 will be well received by the hospital community.

RESPONDER: Robbie Lipsman

4. EMERGENCY ROOMS AND CLINICS ARE BROADLY MISUSED BECAUSE DOCTORS ARE SAID NOT TO MAKE HOUSE CALLS. TELL ME DOCTORS, HOW DO YOU SEE THIS BILL CORRECTING THIS PROBLEM?

In our written testimony we documented one experience we shared with a patient abusing the use of an emergency room because he had great fears of dying. The proposed bill provides a mechanism to prevent such situations from developing for several reasons. Senate Bill 234 establishes programs which can respond to the simplest ailment as well as the critical attack which if left untreated may result in an emergency room admission. Through this mechanism, both clinics and emergency rooms are assisted. The program not only brings the doctor into the home, but a complementary team that can screen medical and social needs and call upon a physician as needed.

The misuse of emergency rooms is not a phenomenon restricted to our own experiences. In testimony delivered before the State of Rhode Island House Committee on Health, Education and Welfare, an experienced physician noted that emergency rooms were often overwhelmed by older patients. His summary comments were simply, "This is not desirable quality medical care."

The introduction of the Community Home Health Care Services Program offers a system to monitor patients who are continually on the verge of serious medical needs. Services can be provided on a regular basis. This alleviates the unnecessary flow to the clinics. It can also serve the totally homebound patient who would normally not reach any medical care, i.e. the emergency room, until a crisis developed.

Our experiences have brought the physician -- the nurse and social worker, too -- into the home, without abuse to the professions. The multi-disciplinary team is able to call upon each other as necessary, thereby encouraging the provision of appropriate care when required.

RESPONDER: Kathryn Zunich, M.D.

5. Homebound aged people suffer from a variety of chronic illnesses which are disabling. These patients exist in the real world, beyond the confines of the hospital. They are critically affected by the reality of their environment, their living space, their ability to care for themselves (or lack of it), their isolation.

As a physician-in-training, the opportunity to learn about and care for such patients with other members of the health care team as would be provided by passage of S234 allows a unique and invaluable experience. I could not obtain this experience in a traditional residency program. It adds to my personal growth as a physician; it helps me better to understand and recognize these patients' special needs which extend far beyond the narrow perspective of the hospital environment. Learning how to manage these patients' chronic illnesses at home and helping them to maintain their independence, is not only personally rewarding but is an important part of medical training which should not be overlooked.

RESPONDER: Linda K. Scharer

6. We have found that discharge planners, staff nurses, social workers and hospital administrators welcome the existence of this kind of program because it provides them with an option not previously available. In addition, the knowledge that the team holds of a particular patient often makes it easier for the staff to understand and treat that patient effectively. Members of the hospital staff have learned that patients who seem quite helpless in the hospital bed often function quite well in their home with minimum supports.

RESPONDER: Philip W. Brickner, M.D.

7. In our experience, patients have responded to this program as would any human being finding a life raft when sinking in a stormy sea. Because long-term home health care programs often give patients a choice in a major life decision, staff members are greeted avidly.

A quotation from one of our patients speaks for many others. She said to us on our arrival: "Thank God you're here. If only you'll keep me out of a nursing home."

The CHAIRMAN. We certainly appreciate your testimony and the more than adequate help you have given this committee in helping us to understand these problems. We appreciate having your associates with you here today as well.

Our second witness on this panel is Mr. Mark Blitz, Assistant Director for Policy and Planning for the U.S. ACTION Agency.

I am grateful for your coming, Mr. Blitz. The senior companion program of ACTION is an important part of our Nation's long-term care program. The frontline views of ACTION are all very important to members of this committee which has direct jurisdiction. We will turn over the time to you at this point.

STATEMENT OF MARK BLITZ, ASSISTANT DIRECTOR, POLICY AND PLANNING, ACTION AGENCY

Mr. BLITZ. Thank you, Mr. Chairman. I am here today to discuss very briefly the senior companion program administered by the ACTION Agency. The senior companion program provides volunteer opportunities for low-income Americans 60 years of age or older. The program coordinates and places volunteers through direct service health-care providers and through social service agencies.

Senior companion volunteers assist older people who are chronically homebound and at risk of being institutionalized. They also assist clients in patient care discharge programs of acute care hospitals, mental health institutions, and other long-term care facilities by easing their transition and adjustment to living in the community.

Low-income senior companions serve 20 hours a week and receive a weekly stipend to help offset the costs of volunteering. During 1981, there were 72 projects funding over 4,000 volunteers and serving 14,000 older adults. The budget authority for the program was \$13,783,000. We estimate that the value of the service contributed was approximately \$33.5 million.

In general, senior companion volunteers throughout the country have helped strengthen the capacity of vulnerable older people,

enabling them to live independently in their home and avoid inappropriate institutionalization. Various evaluations performed by ACTION's evaluation division have shown that the functional capacities both of those served by companions and of the elderly companions themselves is enhanced by the program.

To give a few examples, in Scranton, Pa., 80 senior companions provide services to more than 400 frail elderly. The primary goals of this project are to facilitate discharge from acute care hospitals and to prevent unnecessary readmissions.

In Miami, Fla., a special focus of the project is to serve elderly mental patients. The senior companions are assigned to the patients prior to discharge from the State hospital. Once the person is discharged, the companion continues to provide support services throughout the transition to the community.

In rural Kansas, a 92-year-old widow, whose daughter predeceased her, is able to live alone at home in spite of sight and hearing problems because a senior companion provides assistance to her in daily living activities, including the preparation and sharing of her main meal.

As a final example, in Minnesota, a recent survey of the senior companion program estimated that 264 of 404 clients would most likely have been institutionalized were it not for the program.

Mr. Chairman, I hope that these descriptions and examples provide a useful picture of the Senior Companion program and are suggestive of the potential of volunteer service in some aspects of home health care.

The CHAIRMAN. I appreciate having you here. In the interests of time, I will submit my questions in writing. I would appreciate your getting your answers back promptly.

Mr. BLITZ. We would be happy to respond.

[The prepared statement of Mr. Blitz and responses to questions of Senator Hatch follow:]

Senate Labor and Human
Resources Committee

Hearings on S.234

Testimony by Mark Blitz
Assistant Director, ACTION

The Senior Companion Program provides volunteer opportunities for low-income Americans 60 years of age and older. Established in 1973, SCP enables older people to play a critical role in moderating some of the disadvantages of growing old alone, afraid and frail. The program coordinates and places volunteers through direct-service health care providers, social service agencies, and federal and state long-term care networks. SCP volunteers assist older people who are chronically homebound and at risk of being institutionalized. They also assist clients in patient care discharge programs of acute care hospitals, mental health institutions and other long-term care facilities, by easing their transition and adjustment to living in the community. In all settings, Senior Companions serve as personal representatives, linking clients to appropriate services and ensuring that they receive the benefits to which they are entitled.

Senior Companions serve 20 hours per week and receive a weekly stipend to help offset the costs of volunteering. They also receive transportation assistance, meals on days when they volunteer, annual physical examinations, and accident and personal liability insurance.

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During FY 1981 there were 72 projects, funding 4,114 volunteer years and serving 14,000 older adults. Although the budget authority for the program was 13,783,000 we estimate that the value of service contributed was 33,426,000. In FY 1981, several new projects were developed. These projects were planned and implemented with relevant federal, state and private organizations to ensure that Senior Companions were appropriately integrated into the formal and informal systems that respond to the long-term care needs of adults, and to ensure that they do not duplicate or compete with existing programs or services. Some volunteers serve with mental health community support centers, whose clients include people discharged after long-term or transitional institutionalization. Other Senior Companions have been serving with the terminally ill, people experiencing problems with substance abuse, and patients discharged from acute care hospitals.

In general, SCP volunteers throughout the country have helped strengthen the capacity of vulnerable older people, enabling them to live independently in their home and avoid inappropriate institutionalization. Various evaluations performed by ACTION's Evaluation Division have shown that the functional

capacities both of those served by companions and the elderly companions themselves is enhanced by the program. Some examples will be useful in understanding the program's operation and effectiveness.

Examples

In Scranton, Pennsylvania 80 Senior Companions provide services to more than 400 frail elderly. The primary goals of this project are to facilitate discharge from acute care hospitals and prevent unnecessary re-admissions. Senior Companions meet patients prior to discharge and continue to serve them during the crucial transition period to their own homes. The hospital administration has observed that many patients have been discharged who otherwise would have remained in the hospital because of social problems.

In Miami, Florida (Dade County) 76 Senior Companions provided services to more than 450 elderly people last year. One special focus of this project is to serve elderly mental patients. The Senior Companions are assigned to the patients prior to discharge from the state hospital. Once the person is discharged, the companion continues to provide support services through the transition to the community. More than fifty discharged mental patients have received this service. It is certain that many have avoided re-admission because of the efforts of the Senior Companions.

In rural Kansas, a 92 year-old widow, whose daughter pre-deceased her, is able to live alone at home in spite of sight and hearing problems because a Senior Companion provides assistance to her in daily living activities, including the preparation and sharing of her main meal.

In New York City an elderly man, depressed and withdrawn as a result of a serious arthritic condition, was about to be placed in a nursing home when a Senior Companion was assigned to him. The Senior Companion helped him to obtain homemaker health aid assistance; encouraged him not to dwell on his aches and pains; and escorted him to a Title VII Nutrition Center where he now receives a balanced meal and socialization with his peers.

In Jersey City, New Jersey, when a 90 year-old woman was found in a weak condition in an unheated house which she did not wish to vacate, a Senior Companion came by every evening and morning to stoke her coal furnace. Another Senior Companion assisted in her daily care until a young woman was found to care for the woman in exchange for a live-in arrangement. (As is the case in many other areas, there is a long waiting list for SC assistance, and only the very frail are served, often on a limited basis to spread the help as much as possible.)

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In rural Ohio, an older woman who lived alone and was subject to epileptic seizures was unable to leave her home as friends and neighbors felt unprepared to deal with her possible seizures in public. A Senior Companion who had family experience with epilepsy now accompanies her on outings as well as encourages and assists in her daily activities.

A Senior Companion stays overnight with an elderly cancer patient who had trouble breathing and suffered from nose hemorrhages. The rescue squad taught the Senior Companion how to control the hemorrhages. The recipient feels reassured that he is not alone and uncared for at night; and the rescue squad no longer has to be called in.

In Minnesota, a recent survey of the Senior Companion Program estimated that 264 of 404 clients would most likely have been institutionalized were it not for the program.

I hope that these descriptions and examples provide a useful picture of the Senior Companion Program and are suggestive of the potential of volunteer service in home health care.

QUESTIONS FOR MR. MARK BLITZ, ACTION AGENCY

- 1) THANK YOU FOR YOUR TESTIMONY. THE SENIOR COMPANION PROGRAM IS CERTAINLY AN EXCELLENT EXAMPLE OF HOW A VOLUNTARY PROGRAM CAN MEET THE NEEDS OF A GREAT MANY PEOPLE. COULD YOU PLEASE EXPLAIN THE SENRIO COMPANION PROGRAM VOLUNTEER SELECTION PROCESS?
- 2) DO YOU THINK YOUR PROGRAM COULD BE EFFECTIVE WITHOUT SOME OF THE MORE COSTLY BENEFITS PROVIDED TO THE VOLUNTEERS?
- 3) AS YOU HAVE POINTED OUT IN YOUR TESTIMONY, THERE IS A GREAT NEED TO EDUCATE A COMMUNITY AS TO WHAT AVENUES ARE AVAILABLE TO THEM IN THE HEALTH RELATED SCIENCES. WHAT BENEFITS DO YOU SEE COMING TO AN INDIVIDUAL WHO DECIDES TO PARTICIPATE IN YOUR PROGRAM? WHO DO YOU CONTACT WITHIN A COMMUNITY TO ESTABLISH AN INFORMATION NETWORK?
- 4) HAVE STATE HEALTH AGENCIES AND PRIVATE GROUPS BEEN ENCOURAGED TO START SENIOR COMPANION PROGRAMS?
- 5) WHAT TYPES OF TRAINING DO YOU PROVIDE FOR THE INDIVIDUALS PARTICIPATING IN YOUR PROGRAM? IS IT THE SAME IN EVERY COMMUNITY?

Responses by Mark Blitz, ACTION Agency

- 1) The volunteer selection process is developed and implemented by each individual project. The only criteria established by ACTION reflect the requirements of our legislation. These include the provision that all Senior Companions be over age sixty and have incomes that are below poverty guidelines. The other legislatively-mandated selection criterion is the Civil Rights Act prohibition against discrimination.

The selection process established by the projects generally includes the following criteria: the volunteer must be in reasonably good health, able to provide consistent service and companionship, able to accept supervision, and interested in helping people. The selection interview is generally done by the project director, and in some projects the Advisory Council concurs. In all projects, any applicant who is denied the opportunity to serve has the right to appeal the decision to the Project Advisory Council and ultimately to the sponsor Board of Directors.

- 2) To qualify to receive the benefits of the Senior Companion Program an individual must be low-income. The benefits that are provided are to offset the cost of volunteering and give the low-income person an opportunity he or she would otherwise not be able to afford. It would be doubtful that the program could sustain its volunteer enrollment and effectiveness among those of low income if the benefits were eliminated. However, the program remains cost effective: we estimate that the value of volunteer services is approximately 2 1/2 times the program's budget authority. Moreover, a program similar to Senior Companions, but using higher income volunteers whose costs do not need to be offset can also be effective, although the amount of service is likely to fall short of 20 hours per week. There are several projects in in ACTION's non stipended Retired Senior Volunteer Program that effectively engage in Senior Companion type activities.
- 3) The tangible benefits for each Senior Companion volunteer include the opportunity to provide meaningful service to individuals in need and to the community; the tax-exempt stipend; training that may be applicable to their private lives; an annual physical examination, and the feeling of being needed.

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Senior Companion projects are locally administered by established social service or governmental agencies. These agencies regularly coordinate with the network of human services within their community and are also aided by the fact that the volunteer stations are placed throughout the community in which the program works. The projects also have an Advisory Council that reflects the community make-up in its leadership. In other words, the project does not establish an information system, but, rather, participates in the system that exists in the community.

- 4) At present there are twenty states contributing in excess of two million dollars (2,000,000) directly to ACTION's Senior Companion Programs. ACTION has also established a procedure for non-federally funded Senior Companion Programs to become ACTION affiliates. This means that these programs can receive benefits such as recognition materials, staff training, and technical assistance. We have worked directly with states at their request to establish state-funded projects. Currently there are four projects totally supported with non-ACTION funds.
- 5) ACTION has established standards for the training of volunteers who participate in the Senior Companion Program. Forty hours of pre-service training is required in areas such as emergency procedures, information on available community resources, "how to" serve with the frail elderly, and specific information on the types of people served. Additionally, monthly in-service training (four hours) is provided to each volunteer. The resources available for training vary in each community, but the basic requirements are the same for all projects.

The CHAIRMAN. Our next witness is Mr. Elmer Cerin. It is a special privilege to call upon him because he is the Washington area vice president of the Amyotrophic Lateral Sclerosis Society.

Based on everything I am always hearing, Mr. Cerin, from my staff, committee colleagues, and others in Washington, if there ever was an award given for dedication and the amount of energy expended on Capitol Hill, you have certainly cornered the market on it. We are appreciative to have you with us today.

STATEMENT OF ELMER CERIN, VICE PRESIDENT, AMYOTROPHIC LATERAL SCLEROSIS SOCIETY, WASHINGTON, D.C.

Mr. CERIN. Thank you, Senator Hatch, for inviting me to testify on the revised Community Home Health Services of Act of 1981, S. 234. As revised, this bill would substantially improve the home health care program.

I am a full-time volunteer representative of the Amyotrophic Lateral Sclerosis Society of America. In 1977, when my wife was diagnosed as having this terrible degenerative disorder, commonly called Lou Gehrig's disease, I gave up my legal practice to take care of her.

For 1 year I personally provided all the necessary care. Because of the chronic nature of the illness and its ongoing degenerative prognosis, it soon became evident to me that I would need help. Although I was a member of a health maintenance organization, home health care was not provided. I had no idea where to turn or what agencies provided home health care at reasonable cost. There was no clearinghouse where I could obtain information as to available home health care.

The Department of Human Resources of the District of Columbia informed me that it provided home health care for medicaid eligible patients, but not for those with higher incomes. Therefore, if my wife was to receive the quality of care that I thought was absolutely essential, I would have to provide my own financial resources and physical assistance, or spend down to become medicaid eligible in order to provide the long-term care and help she needed.

As the day-to-day care became unduly burdensome, I hired one nurse's assistant for daytime duty and subsequently another one for night duty. On the weekends, I served around the clock. This assistance made it possible for me to function since it relieved me of approximately 70 to 80 hours in a week. However, I still spent over 80 hours each week to provide the necessary services for my wife.

It should be noted, however, that despite their prior training, I had to instruct both aides in the proper lifting of my wife as well as in other techniques.

For 18 months, I and my two aides worked as a team. We provided excellent service in a very favorable and pleasant environment. Then, at the urging of my family, my wife was admitted to a nursing home when her condition had deteriorated to the point that was beyond our combined capacity and ability to cope with both physically and emotionally.

This nursing home, considered to be one of the best in the Washington area, did not, however, in my opinion provide the kind

and the amount of care that a very sick individual like my wife required. Therefore, for the 7 months my wife was in the nursing home before she died, in addition to a private duty nurse, I spent 8 to 15 hours each day providing the necessary care for my wife because I soon learned of the shortcomings of the staff and the supervision, both in training and in the number of available personnel.

Although the emotional, physical, and financial burdens were at times overwhelming, the quality of care and the environment were far superior in my own home than was available at the nursing home. With the help of the provisions of S. 234, I believe that many of the residents of the nursing home at which my wife was a patient could have been retained in their own home environment during the early stages of their disability and receive better care and at lower costs.

As an individual consumer of home health care, there are two provisions of S. 234 which are particularly important in helping families to keep their disabled members at home, namely, the training of additional personnel in home health care techniques and procedures and encouraging the use of home health care as an alternative to nursing home care by granting an income tax credit for providing such service.

I therefore fully support the enactment of S. 234 as a step toward providing more comprehensive home health care. Again, Senator Hatch, thank you for giving me this opportunity to testify on this important matter.

The CHAIRMAN. Thank you, Mr. Cerin. Again, I will send you questions. I would appreciate your answering.

Mr. CERIN. I would be very happy to do so.

[The prepared statement of Mr. Cerin and responses to questions of Senator Hatch follow:]

STATEMENT OF ELMER CERIN BEFORE THE COMMITTEE ON LABOR AND HUMAN RESOURCES, U.S.SENATE,
ON THE COMMUNITY HOME HEALTH SERVICES ACT OF 1981, S. 234, NOVEMBER 10, 1981

Thank you, Senator Hatch, for inviting me to testify on the revised Community Home Health Services Act of 1981. As revised, this bill would substantially improve the home health care program.

My name is Elmer Cerin and I am a voluntary representative of the Amyotrophic Lateral Sclerosis Society of America. In 1977, when my wife was diagnosed as having the terrible neurological degenerative disorder, amyotrophic lateral sclerosis, commonly called Lou Gehrig's disease, I gave up my legal practice to take care of her.

For one year, I personally provided all the necessary care. Because of the chronic nature of the illness and its ongoing degenerative prognosis, it soon became evident that I would need help. Although I was a member of an health maintenance organization, home health care was not provided. I had no idea where to turn or what agencies provided home health care at reasonable prices. There was no clearing house where I could obtain information as to the available home health care. The Department of Human Resources of the District of Columbia informed me that it provided for Medicaid-eligible patients, but not for those with higher incomes. Therefore, if my wife was to receive the quality of care that I thought was absolutely essential, I would have to use my own financial and physical resources or "spend down" and become Medicaid-eligible in order to qualify for long-term assistance.

As the day-to-day care became unduly burdensome, I hired one nurse's assistant for daytime duty and subsequently another for night duty. On the weekends, I served around-the-clock. This assistance made it possible for me to function since it relieved me of approximately 70 to 80 hours in the week. However, I still spent over 80 hours each week providing the necessary services for my wife. It should be noted that despite their prior training, I had to instruct both aides in the lifting movements as well as in other techniques.

For 18 months I and my two aides worked as a team and we provided excellent service in a very favorable and pleasant environment. Then, at the urging of my family, my wife was admitted to a nursing home when her condition had deteriorated to the point that was beyond the capacity and ability of her caretakers to cope with the situation, both physically and emotionally. This nursing home, considered to be one of the best in the Washington, D.C. area, did not, in my opinion, provide the kind and amount of care that very sick individuals, like my wife, required. Therefore, for the 7 months my wife was in the nursing home before she passed away, in addition to a private duty nurse, I spent 8 to 15 hours each day providing the necessary care for my wife because I soon became aware of the shortcomings of the staff and supervision, both in training and in the number of available personnel.

Although the emotional, physical, and financial burdens were, at times, overwhelming, the quality of care and the environment were far superior at home than was available in the nursing home. With the help of the provisions of S. 234, I believe that many of the residents of the nursing home in which my wife was a patient could have been retained in their own home during the early stages of their disability and receive better care and at a lower cost.

As an individual consumer of home health care, there are two provisions of S. 234 which are particularly important in helping families to keep their disabled members at home, namely, the training of additional personnel in home health care techniques and procedures and in encouraging the use of home health care as an alternative to nursing home care by granting an income tax credit for providing such service.

I, therefore, fully support the enactment of S. 234 as a step toward providing more comprehensive home health care. Again, thank you for giving me this opportunity to testify on this important matter.

QUESTIONS FOR ELMER CERIN

- 1) HOW DID YOU LEARN HOW TO PROVIDE THE NECESSARY HOME HEALTH CARE FOR YOUR WIFE?
- 2) WHEN YOU WERE TAKING CARE OF YOUR WIFE ALONE, DID YOU GET ANY RELIEF?
- 3) ON THE BASIS OF YOUR EXPERIENCE, WOULD YOU HAVE PREFERRED TO KEEP YOUR WIFE AT HOME UNTIL HER DEATH?
- 4) DID YOU RECEIVE ANY MEDICARE BENEFITS?
- 5) IN VIEW OF THE FACT THAT MOST AMERICAN FAMILIES ARE NOW SMALLER AND DISPERSED, DO YOU BELIEVE THAT THE FAMILY CAN PROVIDE HOME HEALTH CARE FOR THE CHRONICALLY ILL FAMILY MEMBER?
- 6) YOU HAVE BEEN KNOWN TO ADVOCATE A "CLEARINGHOUSE" ON HOME HEALTH INFORMATION. COULD YOU PLEASE EXPAND ON THIS? HOW WOULD YOU SET IT UP?

HEARINGS ON THE COMMUNITY HOME HEALTH SERVICES ACT OF 1981. S. 234
Questions and Answers--Elmer Cerin

1)

Q. How did you learn how to provide the necessary home health care for your wife?

A. I learned the procedures and techniques largely by trial-and-error. The most difficult task was lifting my wife from the bed to the wheel-chair, onto the commode and in and out of our automobile. After many painful experiences, I learned the proper technique. In addition, I attended the home care classes given by the American Red Cross. While these classes were helpful, my real training came from the necessity of performing these tasks in taking care of my wife.

2)

Q. When you were taking care of your wife alone, did you get any relief?

A. On several occasions I required respite care to give me some relief. I engaged the services of a home health agency. While the home health aides had some training, they had not been trained to cope with the care required by an ALS patient, such as my wife. In addition, the costs were rather high. This fact is substantiated by a recent report of the U.S. General Accounting Office, entitled Medicare Home Health Services: A Difficult Program To Control (HRD-81-155, September 25, 1981), page 13:

"While home health services have been frequently cited as cheaper than hospitalization or nursing home care, a visit to a doctor's office or a doctor's home visit is often cheaper than a skilled nursing visit or for that matter an aide visit."

3)

Q. On the basis of your experience, would you have preferred to keep your wife at home until her death?

A. On the basis of my experience in my own home and at the nursing home, I would have preferred to have kept my wife at home until her death. This would have required additional help, perhaps one or two health aides to supplement the team of three, my two aides and myself. Even though the costs would have increased, the overall costs at the nursing home would have been higher. Another factor that would have convinced me to keep my wife at home is that at the nursing home the medical staff resorted to overdosing the residents in order to keep them quiet and in a constant stupor.

4)

Q. Did you receive any Medicare benefits?

A. My wife was covered by Medicare. On five occasions, during the early stages of the disease, the doctor prescribed physical therapy. Both physical therapists were of no help to my wife. At that time each visit cost \$30 and lasted less than an hour. In my opinion, the therapy was of no value and was a waste of Medicare funds.

5)

Q. In view of the fact that most American families are now smaller and dispersed, do you believe that the family can provide home health care for the chronically ill family member?

A. Because of the smaller family and its dispersal, home health care by the family of the elderly and the disabled is now far more difficult to achieve. Nevertheless, where the family desires to take care of their sick member, the family should be assisted in providing the necessary services. Thus, home health care is now urgently needed to provide such services to those chronically ill but who desire to be retained in their own home.

6

Q. You have been known to advocate a "clearinghouse" on home health care information. Could you please expand on this? How would you set it up?

A. When long-term illness strikes, the family is usually at a loss where to turn for assistance. There is no central place where information is available as to public and private assistance. Even Medicare and Medicaid information is fragmented. In addition to information, there should be a central control point which would be authorized to approve and evaluate home health care, nursing home care, and other services for the eligible individual. The Triage program, in Connecticut, is an excellent example of a comprehensive health care center which provides information as well as services. I would set up a model facility on the order of Triage or others of equally good performance, such as the Monroe County, New York, plan or the Minneapolis Aging and Opportunity center.

The CHAIRMAN. Finally, I am pleased to call on our two distinguished representatives of the National Multiple Sclerosis Society, Mr. E. Winslow Turner, member of the Government Relations Committee of Holy Cross Hospital, and Marylin Schaengold, also of Holy Cross.

There is not a person in this room who is not familiar with your society's effective and dedicated work. I really thank you for coming and sharing your views with us today.

Mr. Turner and then Ms. Schaengold.

STATEMENT OF E. WINSLOW TURNER, ESQ., GOVERNMENT RELATIONS COMMITTEE, NATIONAL MULTIPLE SCLEROSIS SOCIETY, ACCOMPANIED BY MARYLIN SCHAENGOLD, HOLY CROSS HOSPITAL

Mr. TURNER. Mr. Chairman, I certainly want to thank you for your statement about the Society. I too am a volunteer and am most privileged to sit here next to the gentleman on my left, whom I have always looked at from afar as a shining example of a volunteer.

As you know, our Society is a voluntary health agency of about half a million members and 132 chapters, concentrating on biomedical research and patient services.

With me today is Mrs. Marylin Schaengold of the home care department of Holy Cross Hospital. Mr. Chairman, we have submitted our written statement, and, in the interest of time, I would like to make some brief comments and then turn the rest of the testimony over to Mrs. Schaengold. She is on the firing line and directly experienced with the demands of home health services.

She will provide your committee with a record and some case studies to support her testimony.

A substantial number of patients suffering from MS and other neurological diseases are homebound. However, I want to emphasize this, Mr. Chairman, they are young to middle age homebound, and there is here the potential for a long and costly road of disability.

Although much of the care is initially provided by the family members, most families soon reach a limit and they cannot afford to do what needs to be done. A number of spouses have to quit their jobs and eventually go on welfare. Often a spouse is overwhelmed by the constant involvement as an attendant and the marriage relationship dissolves. Sometimes even younger children, 6 or 7 years old, are left with the total responsibility for a very severely disabled person.

The alternative of institutionalization in a nursing home for younger persons very severely affected by MS is particularly frightening. Most nursing homes do not have special wings or programs for younger persons. Our society has developed a staff training program for nursing homes, but even the better ones are depressing to younger people.

Medicare, and especially the medicaid, programs for home care just do not fill in the gaps in service or reimbursement for some genuine need. Very few private health insurance group plans include home care in their services. A concerted effort to establish or retain such coverage has not been made by either representatives of group plans or the health insurance industry.

Volunteers can fill in some of the gaps around the edges of this problem, but they cannot be expected to perform the basic home care services on a continuing basis. Thus, we must provide the funds for home care services during the day so that the family can concentrate on maintaining the home and take over at night.

It must be a cooperative venture, Mr. Chairman, between members of the family and outside assistance from Government or private organizations, to make a total effort to keep the patient in the home rather than having to warehouse them out to an institution where they will proceed to deteriorate and cause more medical costs by far in the course of their long span, since these may be young people starting out.

That is what I have to say, but I really want to turn my testimony over to Mrs. Schaengold because she knows so much what it is all about. Thank you.

Ms. SCHAENGOLD. As part of the social casework process, an MSW is trained to provide information and referral to community resources, to develop resources where they do not exist, and to act as an advocate for the patient, which I am doing in my testimony today.

As part of a multidisciplinary team of a hospital-based home care certified home health agency at Holy Cross, we care for patients with all diagnostic categories and with different ages, from 3 months to 100. Including our hospice program we have a broad range of experience on age and illness.

Home health aid services are not covered in most insurance policies, nor provided by State or governmental programs. If they

are, there are severe limitations as to time and visits allowable in the home, and the number of hours permissible each day in the home. Four hours a day of care is useful and it is better than no care, but it is not particularly useful if the patients are bedbound and totally dependent upon a caregiver for daily activities of life.

Many multiple sclerosis patients have been disabled for years, and, therefore, the words that are bandied about are chronic, long term, and maintenance, rather than acute, short term, and skilled. Again, insurances and Government programs will not reimburse for home care costs of chronic patients generally. The monitoring and supervision they need from skilled professional staff is not reimbursable.

What the patient and his family need most are home health aides that make possible continued placement of the patient at home. Avoiding institutional placement is paramount when the patient and/or family request it. When the State will reimburse through medical assistance for nursing home care and not reimburse for care in the home, patients are left with few options and further lose their sense of autonomy and independence. In addition to dealing with a debilitating disease, they must deal with a system that rewards institutional care rather than family care.

In the two case study illustrations just provided to the committee and staff—copy attached—I described two patients in what we call a psychosocial diagnostic evaluation. Note that they are a male and a female, both in their fifties, one bedbound, one wheelchairbound, one in a private home, one in public housing, one receiving SSI, one a Government pension. Both these patients can and are being managed at home by the support of home health aid services.

If I can answer any of your questions about what has happened to those two patients since you have read about them, I would be happy to do so.

Thank you.

The CHAIRMAN. Thank you so much. We will submit questions to you.

We just have another vote. What I would like to do is submit questions to you folks. We certainly appreciate the testimony you have given. It has been very beneficial and very helpful to me as chairman and certainly as sponsor of this bill. We appreciate all the work that all of you have done to help so many people throughout your careers and your voluntary activities.

[The prepared statement, additional material, and responses to questions supplied by Mr. Turner follow:]

November 10, 1981

Testimony of

The National Multiple Sclerosis Society

to

The Committee on Labor and Human Resources
United States Senate
4232 Dirksen Senate Office Building

Mr. Chairman and Members of the Committee:

The National Multiple Sclerosis Society is pleased to be asked to testify before this Committee concerning home health care and home care services. We are a voluntary health agency with 132 Chapters covering the entire United States. There are more than one half million citizens who are members of NMSS, and we have devoted our entire attention to the several hundred thousand persons affected by multiple sclerosis and closely related neurological disorders. Our basic concern encompasses both biomedical research to beat the disease and the broad range of services and governmental programs which directly impact on persons with MS and their families.

In our oral testimony, Mr. E. Winslow Turner, attorney and former senior Senate staffer, and coordinator for the Governmental Relations Committee of the National Board of our Society, summarized the nature of our concern and introduced Mrs. Marilyn Schaengold, MSW, Home Care Department, Holy Cross Hospital, Silver Springs, Md. She briefly illustrated her experience in attempting to find appropriate home care services for persons with multiple sclerosis. In summary, our perspective is that an adequate system of home care services which would meet the needs of many persons with multiple sclerosis does not currently exist. Moreover, we believe that an adequate reimbursement structure in governmental programs and private health insurance would be cost-effective compared to the present structure as well as important to preserving individuals' independence and preventing family disintegration.

Recently a task force of our Society has been examining the whole area of home care as it affects those disabled by multiple sclerosis and other chronic disorders. Members of our task force come from a broad range of disciplines and experience on the issue. We have examined the public and the private reimbursement systems and the private insurance coverage plans. We have looked in significant detail at the home health care program conducted by Holy Cross Hospital in Maryland. We have examined some of the positions of home care provider groups and explored questions with groups representing the health insurance industry. We have examined individual case histories and attempted to identify the potentials and the problems existing in this general area. And, we have explored at

some length the degree to which the voluntary system and individual volunteers could help improve the present situation.

Our tentative findings include:

1. A substantial number of younger and middle aged persons with multiple sclerosis are genuinely homebound. Most of their care is provided by family members.
2. The impact on the family with a homebound chronically disabled member is striking. A number of spouses have to quit their jobs and eventually go on welfare. Often a spouse is eventually overwhelmed by the constant involvement as an attendant and the marriage relationship dissolves. Sometimes even younger children of six and seven have total responsibility for very severely disabled persons for many hours.
3. The alternative of institutionalization in a nursing home for younger persons very severely affected by MS is particularly frightening - as well as very costly. Most nursing homes do not have special wings or programs for younger persons. Our Society has developed a staff training program for nursing homes, but even the better ones are depressing to younger residents.
4. The medicare and especially medicaid programs for home care just do not fill in the gaps in service or reimburse for some genuine needs. Waiting lists often involve months of delay before any services can be provided through state medicaid systems. Often the actual needs can only be met to a very limited degree. "Red tape" and coordination difficulties are frequent. Many who should be eligible for home health care services are discouraged in applying or persisting through the eligibility processes.
5. Very few private health insurance group plans include home care as covered services. A concerted effort to establish or retain such coverage has not been made by either representatives of group plans or the health insurance industry. Problems of determining need, quality of services and adequate monitoring and documentation of services have contributed to the relatively low level of interest by insurers in offering such coverage or demand by group plan representatives for such coverage. There has been some experience upon which actuarial information may be able to be obtained, but no one has put it together. These hearings can be helpful in developing data to support a national program of home health care reimbursement.
6. Volunteers can fill in some of the gaps around the edges of this problem, but cannot be expected to perform the basic home care services on a continual basis. This has been tried repeatedly with limited favorable results.

Page 3.

7. The Family Home Care Course conducted by the Chapters of the National Multiple Sclerosis Society and the American Red Cross has been widely attended and has contributed to the home care of patients as well as the stability of families. But, often families simply cannot do everything that needs to be done.

We support S.234 - the Community Home Health Services Act of 1981. We believe it would stimulate care or improved care for some of those persons with multiple sclerosis and other chronic disorders who otherwise may have to be admitted to a nursing home. We favor the opportunity for not-for-profit hospitals to expand a program of community home care services since the continual close liaison between the medical needs and other needs is especially important for persons with neurological disorders.

We hope you will continue to keep us in mind as you develop future legislation on this subject, and again express our appreciation for the opportunity to present to you the perspective of those who actually need home care services.

Submitted by:

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Answers to Questions for
Mr. Winslow Turner and Ms. Marylin Schaengold
National Multiple Sclerosis Society

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- (1) Q. In the past, we have focused on the need for Home Health Services for elderly citizens. Could you please expand on the differences between this need and that of younger home bound citizens you cite with chronic disabilities?
- A. The need for services and the types of services needed by chronically disabled individuals are mostly the same as those needed by elderly citizens. However, the length of time that such services are needed is often longer for those younger home bound persons with chronic disabilities. One of the differences in needs for service arises out of the fact that many younger chronically disabled people are still raising children and have a different set of family needs as a result. Also, among the severely disabled there is an extraordinarily high rate of divorce and single parent homes as well as numbers of severely disabled persons living with their elderly parents. Another aspect of the need of home health services for younger chronically disabled persons arises from the fact that the alternative of nursing home institutionalization is particularly inappropriate for younger people. With only rare exceptions around the country, nursing homes are not set up to serve the needs of younger chronically disabled persons.
- (2) Q. Would you further explain why you maintain that the family is jeopardized by what you describe as an inadequate system of home health services?
- A. Long term institutionalization of a family parent member is itself quite destructive of the family unit. In order to prevent that, many families go to extraordinary lengths to keep a severely disabled family member in the home. But because of the currently inadequate system of home care services, including the lack of reimbursement for some needed services and the limitation on the ability of current programs to provide sufficient services, other problems develop. One of these problems occurs as the spouse takes on the function of incessantly being an attendant and care giver; after a period of time with no significant breaks and respite, some marriages disintegrate to the point where the spouse no longer considers himself or herself a marriage partner but only a care giver. Frequently, substantial financial problems emerge as a spouse is forced to resign from employment in order to provide full time care and, in fact, there are numbers of

cases where marriage breakups occur due to the resulting financial problems. There are numbers of instances where the financial survival of the family and the inability of the family on its own to provide sufficient care, resulted in marriage breakups where the disabled spouse could thereby qualify for Medicaid.

In some homes with a chronically disabled person, younger children, sometimes seven, eight or nine years old, are being given full responsibility for home care for long periods of time in order that the spouse may retain his or her employment. Situations like these frequently result in the need for special family counseling and in some instances, personal child counseling services due to the inability of children of that age to handle the level of responsibility. These are some but by no means all of the factors which result in a negative impact on the family unit of those chronically disabled persons in need of home health care.

- (3) Q. I am grateful to you for your support of my bill, S. 234, one aspect of which is intended to expand the coverage of community home health services provided by hospitals. I know how important the continuing relationship with some form of medical clinic is with persons with multiple sclerosis, and we certainly have an outstanding multiple sclerosis clinic in Salt Lake City. Do you think many more hospitals would establish home care departments if the bill became law?
- A. We are aware that some hospitals in the country are presently qualified for Medicare and Medicaid as home health care providers and that other hospitals are providing community home health services through private programs. The National Multiple Sclerosis Society does not have sufficient experience to make a judgement on the question of whether not-for-profit hospitals should or should not be required to qualify independently as a home health care provider if they are already qualified as an acute care provider for Medicare and Medicaid.

We do have substantial experience to state that we support some form of sufficient incentives to hospitals that would cause them to establish home care departments. Our experience includes support or partial support for many MS clinics in not-for-profit hospitals in the country as well as an elaborate ongoing program dealing with the comprehensive needs of persons disabled with multiple sclerosis. We have found there is a significant need for a continual liaison between medical care and home health care. In the instance of multiple sclerosis and some other types of neurological disorders as well as non-neurological disorders which have a pattern of exacerbation and remission with unpredictable characteristics, the continual liaison between medical specialists and patterns of home health care and home care is a significant need. We see a growing understanding on the part of neurologists in the country of the need to tie together medical care with related survival care and therefore expect that if S. 234 became law some additional hospitals would establish home health care departments.

The CHAIRMAN. With that, we will recess until I can get back from this vote. Then we will finish with our final panel of four witnesses.

[Recess taken.]

The CHAIRMAN. Our final panel for this hearing concentrates on those issues most directly affecting health providers. As I said earlier, testimony of the American Hospital Association and a variety of other organizations as equally influential and representative will be included in the final hearing record in written form.

I am delighted to call upon our first witness, Mr. Don W. Wortley, of Salt Lake City. Mr. Wortley speaks for so many organizations, which is understandable because of his respected reputation. I understand today he is representing the Council of Home Health Agencies and the Community Health Services of the National League of Nursing; the National Homecaring Council; the National Association of Home Health Agencies; and the Home Health Services and Staffing Association.

I also note the participation of Mr. Ron Rosenberg, past chairman of the Home Health Services and Staffing Association. I am very happy to have Mr. Rosenberg here today as well. I am grateful to him today, as I was last March when he also made the long trip here from Kalamazoo.

We will start with Mr. Don W. Wortley and then move into the remaining witnesses.

I am being terribly pressed for time. I am not going to ask any questions orally, but I am going to submit questions to all of the witnesses today.

STATEMENT OF DON W. WORTLEY, RPT, COUNCIL OF HOME HEALTH AGENCIES, COMMUNITY HEALTH SERVICES OF THE NATIONAL LEAGUE FOR NURSING, SALT LAKE CITY, UTAH, ACCOMPANIED BY RONALD ROSENBERG, PAST-CHAIRMAN OF THE BOARD, HOME HEALTH SERVICES AND STAFFING ASSOCIATION, KALAMAZOO, MICH.; EMILY LAYZER, DIRECTOR OF SOCIAL POLICY AND LEGISLATION, NATIONAL HOMECARING COUNCIL, NEW YORK CITY, N.Y.; AND MARY C. SUTHER, CHAIRPERSON, GOVERNMENTAL AFFAIRS COMMITTEE, NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES

Mr. WORTLEY. Thank you.

First of all for introductions, on my immediate right, Mr. Ronald Rosenberg, the immediate past chairman of the Home Health Services and Staffing Association; then Emily Layzer, director of social policy and legislation of the National Homecaring Council; and then Mary Suther, chairperson of the Governmental Affairs Committee of the National Association of Home Health Agencies.

We appreciate this opportunity, Mr. Chairman, to come and testify in relationship to this bill. I would comment briefly that our concerns are not adequately subsumed in the title that you have given us in terms of the panel, that is, reimbursement issues, in that certain quality, quantity, and who provides the service are even of greater import to us, not simply the reimbursement issues.

In our prepared statement, we have presented information substantiating the thesis that home care is cost effective and in short

supply relative to the need in this country. Listening this morning to the GAO report, it seems that their portend is to neutralize these conclusions. I was reminded of the statement that people use statistics like a drunk uses a lightpole, more for support than illumination.

I am sure that in our presentation you will also see a reference to statistics. You can use those for what they are worth. However, from my own personal perspective, being involved with an acute hospital, St. Marks Hospital in Salt Lake City, and also the Salt Lake Community Nursing Service, which is a home health agency, certified and accredited, for the 20 years I have been involved with them, it is in fact cheaper and it is a better way to provide that service.

We have previously presented testimony. In this opportunity to comment, we deal with the specific modifications made in the bill since then. We will not deal with the rest of it that is there.

There are three basic concepts or elements that we will briefly address. First, section 3 under expansion and training: We support increasing service capacity of the certified home health agencies and qualified health professionals.

However, in light of limited Federal resources designated for these purposes, we would like to suggest that the \$5 million authorized for grants and contracts under section 339(a) be available exclusively for the purpose of encouraging expansion and initial development of agencies.

The second issue is that as long as we have cost reimbursement, which has been unwieldy for all providers in all categories—in fact, it is often incomprehensible—there is no process for agencies to accrue capital. Therefore, we need this grant and contract program as a source of capital for expansion and growth.

While we condemn on the one hand the cost reimbursement formula, we are very concerned about changing it because it has been our experience that whenever an attempt has been made to change anything through the regulatory agencies here in Washington, it does not come out better, but it comes out worse. We would caution you, if there is any attempt to change that, to be careful. However, we strongly support continued experimentation with alternative payment systems for use by medicare and medicaid.

Third relates to conditions of participation which we have dealt with before when we were testifying. We feel it important to bring it up again. Certification of a hospital as a result of compliance with conditions of participation for a hospital is not synonymous with compliance of conditions for participation of a home health agency. Those are two distinct certification processes, and the elements of them are vastly different.

We would wonder if certification is the key if it is those individuals who are certified or if it was to be expanded to skilled nursing facilities and others who are certified, which might also be an expectation.

We are also concerned with what we perceive that hospitals deal with a patient as a unit of service, whereas community based agencies consider the family as the basic unit. That is a problem for us.

That is quick. In summary, I would like to applaud your initiative in developing the legislation as you have done. We certainly want to stand in support of what you have done and offer our help in any way we can to get this bill moving.

Thank you very much for the opportunity to present our view.

The CHAIRMAN. Thank you. We really appreciate your coming back and speaking with us today because we know the great service you provide all over Salt Lake City and elsewhere in Utah.

Mr. Rosenberg?

Mr. RONALD ROSENBERG. Thank you, Senator.

In the interests of time, we will submit a written statement. I would just like to compliment you on the continued action you are taking on S. 234 and the goals of that bill to provide more care at home for all the people of this Nation. We would be glad to answer at any time any questions you may have.

[The prepared statement of the National Homecaring Council follows:]

STATEMENT

on

S.234
"The Community Home Health
Services Act of 1981,"

before the

Committee on Labor and Human Resources
The Honorable Orrin G. Hatch, Chairman
United States Senate

presented by

National HomeCaring Council
National Association of Home Health Agencies
Home Health Services and Staffing Association
Council of Home Health Agencies and Community
Health Services of the National
League for Nursing

Washington, D.C.
November 10, 1981

Mr. Chairman and members of the Committee:

A. Introduction

I am Don W. Wortley, Chairman of the Executive Committee of the Council of Home Health Agencies and Community Health Services (CHHA/CHS) of the National League for Nursing.

Here with me today are:

- Ronald E. Rosenberg, immediate past Chairman of the Home Health Services and Staffing Association. Mr. Rosenberg will submit an additional statement for the record which comments on home health care delivery from the for-profit perspective;
- Emily Layzer, Director of Social Policy and Legislation of the National HomeCaring Council headquartered in New York City; and
- Mary C. Suther, Chairperson of the Governmental Affairs Committee of the National Association of Home Health Agencies and Executive Director of the Visiting Nurse Association of Metropolitan Atlanta.

Our organizations together, represent home health agencies of all auspices and are all members of a coalition

-2-

known as the "Forum of Five". Our members provide a substantial part of the home care services available in this country and have accumulated many years of experience with both government and private payment programs.

As you also know, Mr. Chairman, I am a physical therapist at the Salt Lake Community Nursing Service in Salt Lake City, Utah--an agency which provides services to more than 40,000 individuals in our area, including many Medicare and Medicaid patients.

B. Opening Comments

On behalf of these organizations and myself, I want to commend this Committee and particularly you, Mr. Chairman, for your continuing concern and commitment to the advancement of home health care services. This committee is making a significant contribution to our shared goals by bringing wider public attention to the value of home health care services through these hearings and the proposed legislation which is being considered today.

Those of us who are engaged in providing health care to individuals in their homes have long recognized both the cost-effectiveness and the appropriateness of this delivery system for many individuals who might otherwise be sent to institutions.

An example of the cost-effectiveness of home health care is illustrated in a study prepared by the Visiting Nurse Association and Blue Cross in St. Louis, Missouri. (see Appendix A). This study, based on 224 patients referred by Blue Cross to the St. Louis VNA, estimated that, on the average, \$3000 per patient in hospital costs were saved because of the referral to the VNA and the subsequent provision of home care. Other Blue Cross reports from Virginia and Maryland and other reports in the literature also document the net health care savings that can be achieved by the use of home care. Appendix B provides you and the Committee with a list of references to this report.

Cost savings are important, because we are all acutely aware that governmental spending for health care services and programs has been increasing at an alarming and increasingly unacceptable rate. The most recent statistics on national health expenditures published by the Health Care Financing Administration (HCFA) provide striking documentation. Overall spending for health care in the United States in 1980 totaled an estimated \$247 billion, or about 9.4 percent of the gross national product. For Medicare and Medicaid alone, spending in 1980 amounted to \$60.6 billion, of which \$35.8 billion was for hospital care.

More significant has been the rate of increase in federal spending for health care services which, during the period between 1965-1979, averaged 18.6 percent annually. In fact, this growth rate cannot be sustained within the public resources which are projected to be available in future years.

Growth in Medicare payments for home health services has been significant as well. Home health costs in fiscal year 1980 were \$750 million, compared to \$60 million for such services by Medicare in fiscal year 1968. Even so, the 1980 spending level represents less than 2 percent of Medicare outlays. Despite the growth in home health care spending and in the number of agencies providing such services, over 600 of the 3,105 counties in the United States are still without a certified home health agency. Most of these are rural areas with widely dispersed populations. Moreover, the growth in the over sixty-five population and, more importantly, growth in the over seventy-five age group portends an increasing demand for home health care services.

To sum up these observations, Mr. Chairman, we want to emphasize that appropriate and accessible home services must be provided if we are to avoid the costly and very often inappropriate institutionalization of many disabled or chronically ill individuals.

The Congressional Budget Office estimates that only 300,000 to 500,000 adults can be served by personnel from

existing home health care providers, while 1.7 to 2.7 million adults have a need for home care. In addition, according to the CBO, 20-40% of nursing home patients could be cared for adequately without institutionalization if sufficient home health care were available.*/

C. Comments on S.234, "The Community Home Health Services Act of 1981".

We would now like to turn our attention to the revisions which you have proposed to S.234, your bill to encourage the establishment of home health programs and to expand coverage of such programs by Medicare and Medicaid. We have previously testified at hearings before this Committee on S.234 as originally introduced. Today our comments will be directed toward those specific modifications included in the committee print dated October 22, 1981.

We recognize that S.234 is but one aspect of a larger strategy to promote the most cost-effective delivery of health care services through coverage and payment policies which promote the most efficiency and best quality care. In general, we support the objectives of your bill and would like to offer comments and suggestions to the provisions of this bill for the consideration of the Committee.

*/ Budget Issue Paper, Long-Term Care for the Elderly and Disabled, Congressional Budget Office, February 1977, page x.

1. Section 3, Expansion and Training

Section 3 of the draft bill would amend the Public Health Service Act to encourage expansion of home health care services to rural areas through contracts and grants to both public and private agencies. We support this provision and believe it encourages home health agencies, regardless of auspice, to establish or expand services in the areas of greatest need. Further, the grants and contracts could be used to train individuals to provide home health services.

We support efforts to increase the service capacity of certified home health agencies and qualified health professionals to deliver needed services. However, in light of limited Federal resources for these purposes, we would like to suggest that the \$5 million authorized for grants and contracts under Section 339(a) be available exclusively for the purpose of encouraging expansion and initial development of agencies.

Funds for conducting training programs for personnel should be provided for under Section 339(b) as is the case under current law. In particular, we support your preference for training grants and contracts which give special emphasis to training persons over 55 to help provide services in the home. A similar recommendation was made by the "Mini-White House Conference on Long-Term

Care" held last December. That Conference encouraged senior citizen participation in providing health care. As our elderly population increases, particularly in the age range above 75, we believe that involving those older persons whose health permits it in providing home care will prove to be a meaningful source of badly needed personnel as well as create the opportunity for very important work by many senior citizens.

Of course, we recognize that additional training support is authorized under Title XIX of the Social Security Act as amended by the Budget Reconciliation Act of 1980 (P.L. 96-499). This permits up to twelve state demonstration projects for the training of AFDC recipients as home health aide/homemakers. We understand that only two projects will be operational this year.

Training funds already awarded under Section 339 of the Public Health Services Act, have amounted to approximately \$3 million supporting some 77 grants. Over 8,000 home health aides and about 2,200 administrative personnel have participated in these programs, but there are continuing needs, especially for agency managers, information systems specialists and personnel managers.

In making decisions pertaining to applications for grants or contracts under Section 339(a), we urge that the Secretary be required to seek assurances that the applicant has, or is likely to obtain, certification as a participating provider of home health services pursuant to the requirements of Title XVIII and the regulations governing such certification.

We make these recommendations because of our continuing concern that home health services be of high quality and to guard against program mismanagement.

We also underscore the importance of continuing the grants to existing agencies for the purpose of expanding services. A number of grantees under this program have been able to expand their capacity by extending their service area, their hours of operation or their scope of services. To our knowledge, all but one of the agencies which have previously received these grants have continued to operate beyond the period of their assistance.

Finally, in supporting the continuation of this grant and contract program, we would like to point out that the cost-based, retrospective reimbursement system of Medicare and most Medicaid programs makes it impossible for agencies to recover amounts beyond their actual expenses. Thus, the accumulation of capital to support expansion or improvement of services is largely precluded unless other purchasers of home care services provide recognition of these capital requirements. Therefore, the grant and contract program can provide a vital source of capital which is essential to the maintenance and growth of many home health agencies which have no other source of capital.

2. Section 4, Changes in Home Health Services and Providers.

The proposed revisions to S.234 also include amendments to the Medicare and Medicaid programs which are intended to expand coverage for home health services and to liberalize the requirements imposed on providers of such services. We support the proposed amendments to include coverage of nursing care for both acute and chronic conditions and for the services of part-time or intermittent homemaker-home health aid services.

However, we do not believe it is appropriate to include in the statute itself detailed personnel requirements. These are more appropriately addressed in regulations, and we understand that the issue of redefining training requirements for homemaker-home health aides is being considered by the Health Care Financing Administration in the context of revisions to the Medicare Conditions of Participation. In our opinion, these regulations are the appropriate place to address issues such as minimum hours of formal instruction.

We want to especially commend you for including certain non-medical, personal care services and transportation costs. It has been our experience that their exclusion has often made it impractical to maintain certain patients in the home setting, therefore leaving no choice but institutionalization. Under proper supervision and management, we believe these services can prove to be cost-effective when compared with the costs of providing institutional care for many patients. More importantly,

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we believe these changes will enhance the quality of life for many persons who choose to remain in their homes.

We do have some concern with respect to Section 4(b)(5) of the revised bill which further defines the term "home health services". If our interpretation of this language is correct, non-profit hospitals would be eligible to receive reimbursement for services provided in the home by members of its staff even though services would not be provided through a Medicare-certified hospital-based home health agency and would not be reimbursable as outpatient services of the hospital. While we believe hospitals are providing high quality services, we believe that the existing conditions of participation for home health agencies should be imposed on all agencies. These standards are base-line, minimum conditions which were developed after considerable experience with a variety of home care agencies. To waive or suspend those conditions in the case of one type of provider is inequitable and not in the best interests of the patients eligible for Medicare or Medicaid services; particularly when some of these non-profit hospitals already have certified home health agency's.

As an alternative, we suggest for your consideration the possibility of a limited number of grants or contracts to test the validity and appropriateness of agency standards. Non-traditional home health programs have been successfully implemented without government funds in only one or two locations. We believe that, before suspending the regulations imposing agency Conditions of Participation nationally, further experience with alternative models should be obtained. Test sites would also permit the

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collection of financial and utilization data, which are very important factors in projecting the impact of Medicare coverage of hospital outpatient services in the home.

Two other provisions of the proposed bill relating to Medicare and Medicaid warrant comment. The first has to do with home health fiscal intermediaries. We endorse the recent modification in the process for designating intermediaries for home health agencies made by the 1981 Reconciliation Act. While regional intermediaries may improve the efficiency and effectiveness of program administration, we believe there are circumstances in which the opportunity for an agency to select an appropriately qualified national intermediary can be beneficial. Certainly the process of intermediary designation should be publicly accountable and take into consideration the views of the home health providers on both the criteria for selecting regional intermediaries and on the proposed designations.

In addition, there should be an option for all providers to continue dealing directly with the Secretary, as now provided by law, or, in the alternative, to have the option of dealing with another intermediary. We must emphasize that we are not seeking the opportunity for agencies to whip-saw the system and increase administrative costs by allowing providers to jump back and forth between intermediaries. Likewise, we are not proposing a right of nomination for agencies. We do believe, both for cost and equity reasons, that there must be a limited option to choose either the designated regional intermediary or another

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intermediary, also designated by HCFA. Existing law provides for direct dealing with the Secretary; that option has benefits for both the Medicare program and providers. Its benefits must be continued.

Second, we strongly support continued experimentation with alternative payment systems for use by Medicare and Medicaid. While no single methodology has been found completely satisfactory, we are convinced that the present cost-based system and the cost limits now in place do not provide proper incentives or flexibility to the variety of home health agencies participating in the program. Currently, Medicare payments to home health agencies are based on the lesser of reasonable costs or customary charges. Home health agencies are paid during the year based on estimated costs, but final settlements are limited to those costs found by intermediaries to be proper, reasonable, and related to patient care. Final costs settlements often take two or more years.

In effect, home health agencies provide a service in one month, but the price of that service is determined many months later, often two or three years later, and often following much negotiation between the provider and HCFA officials.

Now I ask you, Mr. Chairman, don't you think that there would be a problem in providing a service when you had no idea what you would be paid for it until two years later? In fact, because of its preoccupation with retrospectively determining costs, the present Medicare reimbursement system inhibits innovation and management autonomy which could otherwise lead to

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more efficient and economical delivery of services. Our members are anxious to participate in such experiments, and we believe these experiments are a wise investment of public funds.

3. Section 5, Tax Credit for Home Care.

Section 5 of your proposed bill, Mr. Chairman, includes an amendment to the Internal Revenue Code permitting a tax credit for individuals who maintain in their homes dependent persons over the age of 65. The intent of the provision is to encourage families to keep their older relatives in the home when a medical or mental condition would otherwise require placement in an institution.

We support this provision, but we recognize it is merely a first step in attempting to encourage renewed family participation in the care of the elderly. The tax credit is a modest incentive, and by no means a replacement for money or effort already spent. For example, so long as Medicaid continues in many states to cover the costs of long-term care in an institution, a \$500 tax credit would not offset the additional costs of caring for the impaired individual in the home. On the other hand, we believe that it will make enough of a difference to enough families to be worth the effort.

We emphasize that your tax credit proposal would be limited to care of persons who otherwise would probably be institutionalized, thus assuring that its use will result in real savings of institutional costs. We would like to work with you and your staff in the further refinement of this provision since it arises from a

-14-

shared concern--present policy clearly encourages institutionalization of our elderly and disabled population and thus encourages loss of family responsibility. This bias must be removed and replaced by choices which permit our citizens to receive care in the setting which assures quality, efficiency and personal dignity.

D. Conclusion.

In summary, Mr. Chairman, we want to commend you for taking the initiative with this legislation and these hearings. Each of the organizations before you today stands ready to join with you to develop a constructive approach to improving access to high quality home health care consistent with the limited resources available to meet the health needs of our nation. We fervently believe that home care can not only improve the quality of life for many, but can stretch the health dollar farther.

Thank you for this opportunity to present our views. We look forward to working with you, and we would be pleased to respond to any questions you or other members of the Committee may have.

(Note: In the interest of economy, the appendix material supplied with this statement was retained in the files of the committee where it will be available for research upon request.)

The CHAIRMAN. Thank you so much, and we are happy to have your associates here today.

Not always the most popular question, but certainly the central concern of this inquiry's implementation is the matter of just how much all of this is going to cost. Our next witness is one of the best public accountants in America and certainly carries the reputation of being one of the most knowledgeable in home health care services. I am delighted to call on Mr. William Simione, Jr., with the Boston firm of Simione and Simione.

STATEMENT OF WILLIAM J. SIMIONE, JR., C.P.A., SIMIONE & SIMIONE, PUBLIC ACCOUNTANTS, INC., HAMDEN, CONN.

Mr. SIMIONE. Mr. Chairman, I am Bill Simione, a partner in the certified public accounting firm of Simione & Simione. Our firm represents approximately 130 freestanding home health agencies and is considered to have expertise in the area of home care cost reimbursement.

I have conducted numerous workshops and seminars throughout the country on home health agency reimbursement and fiscal issues. I wish to thank you, Mr. Chairman, for the opportunity to present this testimony.

I am here today to briefly explain the present reimbursement system and how it works, and why in some cases it does not work. Before I explain the reimbursement procedures, we have to familiarize ourselves with who the providers are and what type of services they provide.

As you are aware, currently there are six types of home health agency providers: official, voluntary nonprofit, combination official and voluntary, private nonprofit, proprietary, and provider-based.

Each one of these providers could deliver services ranging from those presently reimbursed under title XVIII to those that are reimbursed by other payor sources. The size of these providers vary from under \$50,000 in total budget to multimillion dollar corporations.

Mr. Chairman, uniqueness is the one word that best describes the providers who deliver home care. Each provider differs in structure, services provided, payor sources, organization, patients, and administrative sophistication.

The medicare program pays providers using a retroactive cost reimbursement system. A very brief description of this procedure is as follows.

Providers bill for covered services at their published charge and are reimbursed accordingly. Providers are required to submit an annual cost report which results in averaged costs of services rendered to medicare beneficiaries. Final retroactive settlement is based on the lower of the charges billed to the medicare program or the average cost of these services as determined by the cost report.

During the cost finding process, certain restrictions are imposed in determining allowable costs. Some of these restrictions are: The cost must be reasonable, the cost must relate to patient care, services rendered by related organizations must be reported at cost and not at inflated charges, a reasonable cost determination for physical therapy furnished by outside providers is made, restricted

revenues are offset against cost, and depreciation guidelines are utilized.

Previously, providers used various cost finding and cost apportionment methods to determine their cost. Effective for cost report periods beginning on or after October 1, 1980, home health agencies must use a single stepdown method of allocating costs to various cost centers.

After the cost finding process has been completed and a cost per visit computed, Federal cost limits are applied to each type of reimbursable service furnished by the home health agency. These limits are classified according to the type of home health agency. The classification is based on whether a home health agency is provider based or free standing and if it is located in an SMSA or non-SMSA area.

There are problems with this cost-based retroactive reimbursement system. These problems are shared by the payor of the services, the provider of the services, as well as the recipient of the services.

Valid criticisms of the system are: There are no cost containment incentives; the reporting requirements are burdensome, but cannot prevent fraud; reasonable cost is not uniformly interpreted by fiscal intermediaries; when used by self-serving individuals, fraud is possible; the system is difficult to administer; the system does not allow profits for all types of providers; the new single method of cost finding is not flexible enough to provide for the uniqueness among the different types of providers.

However, Mr. Chairman, I doubt if any reimbursement system could eliminate these criticisms. Other systems would create new concerns. This bill provides for

The Secretary of Health and Human Services to develop and carry out demonstration projects to test alternative reimbursement mechanisms for home health agencies in order to determine the most cost effective and efficient way of providing home health services.

I wholeheartedly endorse your provision for demonstration projects since the impact and service factors cannot be foreseen at this time. I agree in principle that the Federal Government, as a major purchaser of home health care service, should be in a position to set prices for these services rather than passively reacting to escalating costs.

However, I recommend that the demonstrations should identify relevant factors to insure program integrity via effectiveness of the services being purchased; the demonstrations should utilize known statistical methodologies for determining norms, ranges, and standard deviations for groupings or categories of providers, costs, or application of rates; the demonstrations should be sensitive to the effectiveness of the program and provide incentives to the most efficient providers, not only those home health agencies with the lowest cost.

Mr. Chairman, I commend you and the distinguished members of your committee for the initiatives in S. 234 to encourage the advancement of home care services. If our firm can provide assistance in the future, we would be most willing to do so.

[The prepared statement of Mr. Simone follows:]

TESTIMONY OF WILLIAM SIMIONE, JR., C.P.A.

MR. CHAIRMAN, I AM BILL SIMIONE, A PARTNER IN THE CERTIFIED PUBLIC ACCOUNTING FIRM OF SIMIONE AND SIMIONE. OUR FIRM REPRESENTS APPROXIMATELY 130 FREE-STANDING HOME HEALTH AGENCIES AND IS CONSIDERED TO HAVE EXPERTISE IN THE AREA OF HOME CARE COST REIMBURSEMENT. I HAVE CONDUCTED NUMEROUS WORKSHOPS AND SEMINARS THROUGHOUT THE COUNTRY ON HOME HEALTH AGENCY REIMBURSEMENT AND FISCAL ISSUES. I WISH TO THANK YOU, MR. CHAIRMAN, FOR THE OPPORTUNITY TO PRESENT THIS TESTIMONY.

I AM HERE TODAY TO BRIEFLY EXPLAIN THE PRESENT REIMBURSEMENT SYSTEM AND HOW IT WORKS, AND IN SOME CASES WHY IT DOES NOT WORK. BEFORE I EXPLAIN THE REIMBURSEMENT PROCEDURES, WE HAVE TO FAMILIARIZE OURSELVES WITH WHO THE PROVIDERS ARE AND WHAT TYPE OF SERVICES THEY PROVIDE. AS YOU ARE AWARE, CURRENTLY THERE ARE SIX TYPES OF HOME HEALTH AGENCIES:

- OFFICIAL
- VOLUNTARY NON-PROFIT
- COMBINATION OFFICIAL AND VOLUNTARY
- PRIVATE NON-PROFIT
- PROPRIETARY
- PROVIDER-BASED

EACH ONE OF THESE PROVIDERS COULD DELIVER SERVICES RANGING FROM THOSE PRESENTLY REIMBURSED UNDER TITLE XVIII TO THOSE THAT ARE REIMBURSED BY OTHER PAYOR SOURCES. THE SIZE OF THESE PROVIDERS VARY FROM UNDER \$50,000 TO MULTI-MILLION DOLLAR CORPORATIONS. MR. CHAIRMAN, UNIQUENESS IS THE ONE WORD THAT BEST DESCRIBES THE PROVIDERS WHO DELIVER HOME CARE. EACH PROVIDER DIFFERS IN:

- STRUCTURE
- SERVICES PROVIDED
- PAYOR SOURCES
- ORGANIZATION
- PATIENTS
- ADMINISTRATIVE SOPHISTICATION

(2)

THE MEDICARE PROGRAM PAYS PROVIDERS USING A RETROACTIVE COST REIMBURSEMENT SYSTEM. A VERY BRIEF DESCRIPTION OF THIS PROCEDURE IS AS FOLLOWS:

- PROVIDER BILLS FOR COVERED SERVICES AT THEIR PUBLISHED CHARGE AND IS REIMBURSED ACCORDINGLY.
- PROVIDERS ARE REQUIRED TO SUBMIT AN ANNUAL COST REPORT WHICH RESULTS IN AVERAGED COSTS OF SERVICES RENDERED TO MEDICARE BENEFICIARIES.
- FINAL RETROACTIVE SETTLEMENT IS BASED ON THE LOWER OF THE CHARGES BILLED TO THE MEDICARE PROGRAM OR THE AVERAGE COST OF THESE SERVICES AS DETERMINED BY THE COST REPORT.

DURING THE COST FINDING PROCESS, CERTAIN RESTRICTIONS ARE IMPOSED IN DETERMINING ALLOWABLE COST. SOME OF THESE RESTRICTIONS ARE:

- COST MUST BE REASONABLE
- COST MUST RELATE TO PATIENT CARE
- SERVICES RENDERED BY RELATED ORGANIZATIONS MUST BE REPORTED AT COST NOT INFLATED CHARGES
- A REASONABLE COST DETERMINATION FOR PHYSICAL THERAPY SERVICES FURNISHED FROM OUTSIDE SUPPLIERS
- RESTRICTED REVENUES ARE OFFSET AGAINST COST
- DEPRECIATION GUIDELINES ARE UTILIZED

PREVIOUSLY, PROVIDERS USED VARIOUS COST FINDING AND COST APPORTIONMENT METHODS TO DETERMINE THEIR COST. EFFECTIVE FOR COST REPORT PERIODS BEGINNING ON OR AFTER OCTOBER 1, 1980 HOME HEALTH AGENCIES MUST USE A SINGLE STEP-DOWN METHOD OF ALLOCATING COSTS TO VARIOUS COST CENTERS.

(3)

AFTER THE COST FINDING PROCESS HAS BEEN COMPLETED AND A COST PER VISIT COMPUTED, FEDERAL COST LIMITS ARE APPLIED TO EACH TYPE OF REIMBURSABLE SERVICE FURNISHED BY THE HOME HEALTH AGENCY. THESE LIMITS ARE CLASSIFIED ACCORDING TO THE TYPE OF HOME HEALTH AGENCY. THE CLASSIFICATION IS BASED ON WHETHER A HOME HEALTH AGENCY IS PROVIDER-BASED OR FREE-STANDING AND IF IT IS LOCATED IN A S.M.S.A. OR NON-S.M.S.A. AREA.

THERE ARE PROBLEMS WITH THIS COST-BASED, RETROACTIVE REIMBURSEMENT SYSTEM. THESE PROBLEMS ARE SHARED BY THE PAYOR OF SERVICES, THE PROVIDER OF SERVICES, AS WELL AS THE RECIPIENT OF THESE SERVICES. VALID CRITICISMS OF THE SYSTEM ARE:

- THERE ARE NO COST CONTAINMENT INCENTIVES
- THE REPORTING REQUIREMENTS ARE BURDENSOME, BUT CANNOT PREVENT FRAUD
- REASONABLE COST IS NOT UNIFORMLY INTERPRETED BY FISCAL INTERMEDIARIES
- WHEN USED BY SELF-SERVING INDIVIDUALS, FRAUD IS POSSIBLE
- THE SYSTEM IS DIFFICULT TO ADMINISTER
- COST REPORT MANUAL INSTRUCTIONS ARE APPLIED RETROACTIVELY
- THE SYSTEM DOES NOT ALLOW PROFITS FOR ALL TYPES OF PROVIDER
- THE NEW SINGLE METHOD OF COST FINDING IS NOT FLEXIBLE ENOUGH TO PROVIDE FOR THE UNIQUENESS AMONG PROVIDERS

HOWEVER, MR. CHAIRMAN, I DOUBT IF ANY REIMBURSEMENT SYSTEM COULD ELIMINATE THESE CRITICISMS. OTHER SYSTEMS WOULD CREATE NEW CONCERNS. THIS BILL PROVIDES FOR "THE SECRETARY OF HEALTH AND HUMAN SERVICES TO DEVELOP AND CARRY OUT DEMONSTRATION PROJECTS TO TEST ALTERNATIVE REIMBURSEMENT MECHANISMS FOR HOME HEALTH AGENCIES IN ORDER TO DETERMINE THE MOST COST-EFFECTIVE AND EFFICIENT WAY OF PROVIDING HOME HEALTH SERVICES."

(4)

I WHOLEHEARTEDLY ENDORSE YOUR PROVISION FOR DEMONSTRATION PROJECTS SINCE THE IMPACT AND SERVICE FACTORS CANNOT BE FORESEEN AT THIS TIME. I AGREE IN PRINCIPLE THAT THE FEDERAL GOVERNMENT, AS A MAJOR PURCHASER OF HOME HEALTH CARE, SHOULD BE IN A POSITION TO SET PRICES FOR THESE SERVICES, RATHER THAN PASSIVELY REACTING TO ESCALATING COSTS. HOWEVER, I RECOMMEND THAT:

- THE DEMONSTRATIONS SHOULD IDENTIFY RELEVANT FACTORS TO ENSURE PROGRAM INTEGRITY VIA EFFECTIVENESS OF THE SERVICES BEING PURCHASED.
- THE DEMONSTRATIONS SHOULD UTILIZE KNOWN STATISTICAL METHODOLOGIES FOR DETERMINING NORMS, RANGES AND STANDARD DEVIATIONS FOR GROUPINGS OR CATEGORIES OF PROVIDERS, COSTS, OR APPLICATION OF RATES.
- THE DEMONSTRATIONS SHOULD BE SENSITIVE TO THE EFFECTIVENESS OF THE PROGRAM AND PROVIDE INCENTIVES TO THE MOST EFFICIENT PROVIDERS NOT ONLY THOSE HOME HEALTH AGENCIES WITH THE LOWEST COST.

MR. CHAIRMAN, I COMMEND YOU AND THE DISTINGUISHED MEMBERS OF YOUR COMMITTEE FOR THE INITIATIVES IN S.234 TO ENCOURAGE THE ADVANCEMENT OF HOME CARE SERVICES.

IF OUR FIRM CAN PROVIDE ASSISTANCE IN THE FUTURE, WE WOULD BE MOST WILLING TO DO SO. IF THERE ARE ANY QUESTIONS YOU OR OTHER MEMBERS OF THE COMMITTEE HAVE, I WILL DO MY BEST TO ANSWER THEM.

The CHAIRMAN. Thank you so much, Mr. Simone.

Our final witness today is the president of the American Federation of Home Health Agencies, Mr. Ron Reck.

I want you to know, Mr. Reck, that I sent copies of AFHHA's summary and reprint of the Helen Hayes televised special on long-term care to an avalanche of people in my own home State. I want to thank you again for providing them for me.

I also want to thank you both for your patience this morning and for your agreement to come once again and testify on this bill.

**STATEMENT OF RONALD B. RECK, PRESIDENT, AMERICAN
FEDERATION OF HOME HEALTH AGENCIES, PITTSBURGH, PA.**

Mr. RECK. Thank you, Senator.

For the record, my name is Ron Reck. I am the present administrator of the Home Health Services of Allegheny County located in Pittsburgh, Pa. I am also the president of the American Federation of Home Health Agencies, a national trade association representing the small business freestanding home health agencies nationwide.

As stated in earlier testimony that we gave on March 4, 1981, we are pleased that you, Senator, recognize the need for a greater emphasis on medical care in the home environment. Hopefully, S. 234 will provide that more needed care and also care at a less costly alternative to the institutionalized care.

For the sake of time, I have tried to wipe out some of the testimony and I will move quickly. As originally introduced, S. 234 authorized certain home health services which could only be provided by a nonprofit hospital. We testified in opposition to that discrimination favoring the hospital based home health agencies over the freestanding agency.

While these provisions which would have severely limited competition by the small business sector were eliminated and modified, the federation is still concerned that the revised S. 234 retains discriminatory provisions favoring nonprofit hospital based agencies.

Hospitals operating noncertified programs could receive medicare and medicaid reimbursement without complying with the standards that were mandated for all home health providers as set out in 42 U.S.C. 1395M. Thus, uniform standards that were designed to assure high quality care and delivery of quality of services in home health care at a reasonable cost will not apply to a select group of providers. We firmly believe that only certified home health agencies should participate in the medicare program.

For example, as laid out in S. 234, if St. Vincent's Hospital in New York City or any hospital wishes to participate in these programs, then they should be certified as a home health agency. Their certification as a hospital does not give them cause or reason to go into providing home health care. They are two different things, as Mr. Wortley has stated earlier. Prior medicare and medicaid certification as a hospital provider should not allow automatic reimbursement for home health services.

On the prospective reimbursement issue, the American federation has long supported the concept of replacing the current cost reimbursement system. We have laid out a system for your committee which has an SBO effect. We will probably pull and give

you some more information on the reimbursement system, but it is a prospective reimbursement system with incentives built in for home health agencies.

On the dual cost cap situation which we discussed at our last hearing with you and tried to lay out the cost saving proposal up here on the Hill and with the Health Care Financing Administration, to recap, under HCFA's present interpretation of the law—this is another discriminatory act that we find with hospitals versus freestanding agencies—the provider based agency or hospital is reimbursed up to 59 percent more for the same services being provided by a freestanding agency.

It is important to note that there is no difference in either the quality of services provided by the two types of home health providers or in the types of patients being serviced.

The Health Care Financing Administration justification for the higher reimbursement rates for provider based hospitals is based on HCFA's own system of allocation of hospital overhead costs.

The federation does not find the system responsible, prudent, or cost effective. Hospitals should not receive reimbursement for costs not necessary for the delivery of home health services.

In conclusion, the American Federation of Home Health Agencies would like to recommend a consideration which will be very important to the home health industry, the Congress, and to hopefully the Health Care Financing Administration. That would be a provision in the bill to eliminate any discriminatory and noncompetitive higher reimbursement rates for hospital based home health agencies.

We therefore request that S. 234 be amended to include a provision precluding duality in cost caps and allow a freestanding small business type home health agency and hospital based home health agencies to compete on equal terms in the marketplace.

I thank you very much for allowing me this opportunity to speak.

[The prepared statement of Mr. Reck follows:]

• AFHHA •

AMERICAN FEDERATION OF HOME HEALTH AGENCIES, INC.

POST OFFICE BOX 330 - VERONA, PENNSYLVANIA 15147

(412) 362-8600

WRITTEN STATEMENT OF THE
AMERICAN FEDERATION OF HOME HEALTH AGENCIES
BEFORE THE
SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES
ON
S.234

THE COMMUNITY HOME HEALTH SERVICES ACT OF 1981

RONALD B. RECK
PRESIDENT

NOVEMBER 10, 1981

• AFHHA •

AMERICAN FEDERATION OF HOME HEALTH AGENCIES, INC.

POST OFFICE BOX 330 - VERONA, PENNSYLVANIA 15147

(412) 362-8600

BACKGROUND

RONALD B. RECK

PRESIDENT

AMERICAN FEDERATION OF HOME HEALTH AGENCIES

RONALD B. RECK IS CURRENTLY THE ADMINISTRATOR OF HOME HEALTH SERVICES OF ALLEGHENY, CO., PITTSBURGH, PENNSYLVANIA. HE FORMERLY SERVED ON THE NATIONAL LEAGUE FOR NURSING - - COUNCIL OF HOME HEALTH AGENCIES AND COMMUNITY HEALTH SERVICES COMMITTEE FOR PRIVATE AGENCIES AND THE NATIONAL REIMBURSEMENT TASK FORCE OF INTERMEDIARIES AND VARIOUS HOME HEALTH AUSPICES. AN EXPERT IN MEDICARE MEDICAL CLAIM DENIALS AND APPEALS PROCESSES, RONALD RECK HAS ORGANIZED NATIONWIDE SEMINARS AND PROGRAMS ON MEDICARE CLAIM DENIALS. HE IS ONE OF THE FOUNDERS AND CURRENT PRESIDENT OF THE AMERICAN FEDERATION OF HOME HEALTH AGENCIES, A NATIONAL TRADE ASSOCIATION REPRESENTING SMALL BUSINESS - FREE STANDING HOME HEALTH AGENCIES NATIONWIDE.

• AFHHA •

AMERICAN FEDERATION OF HOME HEALTH AGENCIES, INC.

POST OFFICE BOX 330 - VERONA, PENNSYLVANIA 15147
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Mr. Chairman and Distinguished Members of this Committee
-- My name is Ronald B. Reck, I am Administrator of Home Health Services of Allegheny County located in Pittsburgh, Pennsylvania and I am President of the American Federation of Home Health Agencies (AFHHA), a national trade association representing small business free standing home health agencies throughout the United States. I am very pleased to have this opportunity to present our association's views on the revised version of Senate Bill S-234, "The Community Home Health Services Act of 1981."

As stated in our earlier testimony given on March 4, 1981, AFHHA is pleased that Senator Hatch recognizes the need for a greater emphasis on medical care in the home environment. S-234 acknowledges home health care as a less costly alternative to institutional care and is often more humane in that it improves a patient's quality of life without diminishing the quality of care provided.

Uniform Standards for Participation

As originally introduced, S-234 authorized certain home health services which could only be provided by non-profit hospitals. We testified in opposition to this discriminatory

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favoring of the hospital-based home health agency over free-standing home health agency. While these provisions which would have severely limited competition by the small business free-standing agency were modified, AFHHA is still concerned that the revised S-234 retains discriminatory provisions favoring non-profit hospital based agencies. Hospitals operating non-certified programs could receive Medicare and Medicaid reimbursement without complying with the standards mandated for all other home health providers (see, 42 U.S.C. 1395M). Thus, uniform standards designed to assure high quality care and delivery of quality services at a reasonable cost will not apply to a select group of providers. AFHHA believes that only certified home health agencies should participate in the Medicare-Medicaid program. If St. Vincent's Hospital in New York City or any hospital wishes to participate in those programs in order to best serve the needs of their patients, they should be willing to do so by qualifying with their State Certification requirements and complying with the conditions of participation as set forth in 42 CFR 405.1201. St. Vincent's Hospital is a fine and well recognized hospital but their home health services are not better than those provided by my agency or scores of other agencies throughout this United States. It would be unconscionable to provide them with preferential treatment. Prior Medicare-Medicaid Certification as a hospital provider should not allow automatic reimbursement for home health services.

Prospective Reimbursement

Section 4(f) of revised S-234 would require the Department of Health and Human Services to develop and carry out demonstration projects to test alternative reimbursement mechanisms for home health agencies in order to determine the most cost effective and efficient way of providing home health services. Those methodologies to be tested by the department are required to include prospective reimbursement.

AFHHA strongly endorses this provision. The American Federation of Home Health Agencies has long supported the concept of replacing the current cost reimbursement system with a prospective reimbursement system. We believe that the present retroactive cost reimbursement system is unmanageable. We would propose a prospective system with profit incentives in mind designed specifically for home health agencies. Such a system, would reward business efficiency, maintain and enhance the quality within the system, eliminate retroactive denials, eliminate the Provider Reimbursement Review Board for home health agencies, eliminate a significant portion of costs associated with fiscal intermediary audit review and cost report settlements, and reduce overall cost of the program

Many ways have been proposed for determining the method of payment to home health agencies. Under a prospective reimbursement system our recommendation would be that a set payment would be provided for each agency in a specific geographic area. Each agency would be allowed to conduct their business up to this per visit payment amount and percentage of the difference between their costs and the payment would be returned to them as profit. An important function of this profit motive is to weed out inefficient agencies.

The existence of related organizations would be under such a system. This system is free enterprise oriented and promotes efficiency rather than encouraging waste.

The fraudulent agency that bills for unperformed visits could be a problem as would the agency which sought to reduce the quality of care provided. To deal with such practices, AFHHA is proposing the creation of a quality control system we will refer to as SPO which stands for Structure, Process and Outcome. While the development of a detailed position paper by the association on this proposal is still underway, we would be pleased to attempt to respond to any question you may have on this issue.

Dual Cost Caps

As stated in our earlier testimony, there are several types of entities which provide medical care in the home. These include hospitals, private non-profit and proprietary agencies, Visiting Nurse Associations, and official health departments. Under HCFA's present interpretation of the law, the provider-based home health agency is reimbursed up to 59 per cent more for the same services being provided by the free-standing home health agency. It is important to note that there is no difference in either the quality of services provided by the two types of home health agencies or in the types of patients being cared for.

The Health Care Financing Administration's justification for the higher reimbursement rates for provider-based home health agencies is based on HCFA's own system of allocation of hospital overhead expenses. AFHHA does not find this system responsible, prudent or cost-effective. Hospitals should not receive reimbursement for costs not necessary for the delivery of home health services.

We believe that provider-based agencies are taking advantage of the higher reimbursement rate whenever possible. There is no incentive to try to contain costs at the same level as those of free-standing agencies. If a hospital can divert a portion of overhead cost to home health component,

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then the average in-patient cost will appear lower, and the Medicare reimbursement will increase cash flow, thus enabling the hospital to remain under in-patient limitations. A more accurate picture of the overall cost for in-patient versus home health care expenditures would be realized if reimbursement rates were the same for both provider-based agencies and free-standing agencies.

Conclusion

The costs of treating patients in the home are significantly lower than hospitalization. While everyone recognizes this fact, more needs to be done to promote and encourage home health care.

S-234's amendments to the Public Health Services Act and Internatl Revenue Code will encourage expansion of these needed services. The addition of physician, respiratory therapists and other health workers for the treatment of chronically ill Medicare and Medicaid patients are necessary and cost effective improvements; however, S-234's creation of a new type of home health provider, the non-profit hospital, is unlikely to cause expansion through initial operation in areas with inadequate means of transportation or in areas of populations having high percentages of elderly or medically indigent individuals.

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Expansion and continued service in these priority areas is dependent upon an improved Medicare-Medicaid reimbursement system and the establishment of meaningful fee for services, payment by other third party payers. Government and charitable support can only support a limited home health industry which cannot adequately meet the needs of a growing demand. An influx of private capital is needed.

AFHHA therefore supports the proposal contained in the Bill to require a demonstration project on alternative reimbursement mechanisms for home health agencies. We would request a provision be added requiring the secretary to work closely with the home health industry in developing and instituting this demonstration project. We have found over the years that the Health Care Financing Administration which would likely administer this demonstration project, has worked at arm's length with our industry. While the cooperative atmosphere has improved recently, we would appreciate a provision included in the Bill which would require HCFA to work with us as they develop this project. We believe our SPO program could be a helpful approach in the project.

Finally, we have a recommendation which we consider very important for both this industry and the Congress's desire to reduce costs to the Medicare Program. That would be a provision in the Bill to eliminate discriminatory and non-competitive

higher reimbursement rates for hospital-based home health agencies. We, therefore, request that S-234 be amended to include a provision precluding duality in cost caps and allow a free-standing and hospital-based home health agency to compete on equal terms as to price and quality of services.

We thank the Labor and Human Resources Committee for the opportunity to present the views of the small business free-standing home health agencies across the United States. We look forward to working with the Committee and its staff in the final preparation of S-234.

The CHAIRMAN. Thank you very much, Ron. We appreciate your testimony.

In the wake of all that has been said here today and before we adjourn this hearing, I draw your attention to the following paragraph which I believe puts everything in perspective:

It has not been widely acknowledged—though there are those who recognized the point—that the principal problem socially in America during the next twenty or thirty years is not going to be the problem of overpopulation, nor Soviet recklessness nor nuclear war, but the problem of caring for our aged. In the last 20 years, we have increased by ten years the predictable actuarial lifespan of the man who is 65 years old. As a result of heroic geriatric efforts, we have prolonged the efforts of my parents, and your grandparents, to a point that is a tribute to our instincts to permit people to live as long as they can. But as so often happens, it is an instinct that does not face some of the complementary problems which go with it, the necessity of expanding home health care services.

That the author of the eloquent paragraph I just read is conservative author and columnist, William F. Buckley, Jr., further illustrates the fact that support for home health care is not confined to any one ideology, political party, or point of view. The need for it has already been demonstrated.

Support for long-term care policy reform has already been established. It is now up to all of us to use what we have learned here today to make the wider availability of quality home health care services a reality for tomorrow.

In particular, I would like to thank members of my staff, Judy Stefanki, Dr. Docksai, Dr. Sundwall, Deb Turner, and other members of the staff for the really yeoman efforts that they have put in in working so hard to have these hearings come to fruition, and of course to have this bill written in as fine a form as it really is. Their dedication really means a great deal to me, but more importantly to everybody in America.

At this point I order printed all statements of those who could not attend and other pertinent material submitted for the record.
[The material referred to follows:]

STATEMENT OF THOMAS I. HARNISH,
PRESIDENT & CHIEF OPERATING OFFICER
RESPICARE, INC., COLUMBUS, OHIO

to

COMMITTEE ON LABOR AND HUMAN RESOURCES
THE HONORABLE ORRIN G. HATCH, CHAIRMAN
UNITED STATES SENATE

ON

S.234

"THE COMMUNITY HOME HEALTH SERVICES ACT OF 1981"

November 10, 1981, Washington, D.C.

December, 1981

Mr. Chairman and Members of the Committee:

Your diligence in pursuing legislation which will expand home health care services in this country and encourage families to provide care for elderly dependents in the home is highly commendable. It represents a major milestone in health care that is long overdue. S.234 has the potential of improving the lives of many afflicted people in America, including the handicapped, chronically ill and infirm. But, in terms of the elderly, it creates new hope. "The Community Home Health Services Act of 1981", if developed into legislation, creates opportunities for our older population to live happier more productive lives through greater independence and control over their lifestyles.

During my career in health care, which spans almost 30 years, I have been involved in many facets of administration, development, regulation, teaching and evaluation. I have been involved with hospitals, university complexes, government agencies, think tanks and private industry (See Appendix I for a detailed Vita). The hospitals I have planned and managed are valued in excess of \$100 million. On the other side of the coin, I have served as Founding Director of the Ambulatory Care Council of the Joint Commission on Accreditation of Hospitals.

However, the career achievements of which I am most proud are related to bringing urgently needed health care services

to rural areas in the United States and underdeveloped countries abroad. My present efforts to pioneer new services and products in our nation's home health service (HHS) industry have evolved from a deep conviction that "the hospital without walls" concept is a viable alternative to costly institutionalization. As I witnessed over the years the continued spiral of health care costs in this country, I began to realize an alternative must be sought. I appreciate your action which reinforces my conviction and demonstrates genuine concern over the state of health care for the elderly.

Your committee has heard many hours of expert testimony and has conducted research into the causes and effects of the complex matrix of socio-economic and political factors impacting our existing health care delivery system. It is not my attention to use this forum to rehash all the problems or introduce new findings; rather, I am compelled to offer insights I have gained from experience. Hopefully, your attention to these considerations will have a bearing on the ultimate scope and content of S.234.

As an innovator in the incipient home health care industry ... an industry which holds great promise for restoring the dignity of millions ... I am pleased to testify in favor of your proposed program of expanded services and tax incentives. I can

also appreciate the economic objectives underlying this legislation: to lighten the burden of uncontrollably escalating health care costs, shouldered by government, business and individuals.

While I concur wholeheartedly with the general direction of S.234, I would take this opportunity to make some specific suggestions related to the scope and content of services so to provide for the full range of Home Health Service (HHS) needs. My recommendations also are offered to help streamline the HHS system through application of strategic planning and professional management practices. Finally, I hope to alert the Committee to what I consider an imminent threat of great consequence to the success of HHS in this country: the danger of existing institutions, such as hospitals, nursing homes and other agencies gaining "monopolizing" control over the HHS delivery system. This development, I believe, would lead to a prejudicial situation (comparable to our present health care dilemma) wherein special interests could conceivably dominate what services become developed, where these services are made available and, of course, the cost of these services. The ultimate result of a limited delivery system would be an inefficient, inequitable HHS service with the same dilemma of escalating costs that plague our present health industry.

Before presenting specific insights and recommendations, I would like to reiterate some of the facts I consider paramount

in presenting an alternative to our present health care system in America. The rather bleak picture painted below with the broad brush of generalized, quantitative findings clearly points to our acute need for action to alleviate the economic and social hardships inherent in sickness and aging today.

HEALTH CARE IN AMERICA/1981

There can be little doubt that the health care problem in America is reaching crisis proportions. When 44 percent of our population cannot afford adequate health care because of skyrocketing costs¹, when between 1.7 and 2.7 million people are "incarcerated" in institutions or held for prolonged periods in expensive hospitals because of unavailable HHS² and when the cost of health care in the present system continues to escalate in combination with a rapidly aging population, we as taxpayers, family members and society are in serious trouble. The grim facts are:

- . Since 1950 the cost of a hospital stay has increased over 1,000 percent (over eight times the rise in Consumer Price Index).
- . Last year a hospital admittance averaged \$3,000 with the average American spending \$1,000 a year for basic medical care.
- . The total cost of medical care in the United States is mushrooming at an average of sixteen percent a year.
- . In 1980, the United States spent over \$240 billion on medical care (with the government paying 41 percent of the nation's \$85.3 billion hospital bills in 1979³). At this unchecked rate, we'll spend close to \$300 billion in health care in 1982.

It is no wonder that an alternative through HHS is on the rise in America. A recent report by the Institute for Program Evaluation⁴ reveals: "Medicare's coverage of Home Health Services represents one of the fastest growing health expenditures for the Federal government. It is estimated in FY82 \$1.146 billion will be spent on Medicare benefit payments for home health services.⁵ This is an increase of about 300 percent over the \$287 million spent in FY76.⁶ The number of Medicare home health visits has also increased from 8.1 million in 1974 to 17.3 million in 1978."⁷

Yet the reasons for a rise in use and popularity of HHS are more than economic. There are no neat, poignant statistics, to my knowledge, detailing the number of families who have experienced the disintegrative effects of having to place loved ones in institutions. Or on families who have been destroyed emotionally (and financially) from the costs of institutionalized acute or chronic care for illness victims. Not to mention the dearth of statistics describing the millions depressed or rendered dysfunctional by the psychological guilt of not being able to care for family members in the home environment. How many bankruptcies, how many second mortgages, how many divorces, how many suicides -- we'll probably never know definitive answers to these questions, other than "too many."

But let's look at it from the perspective of a person growing old in this society -- a fate we all share. In a paper by Dr. James J. Dowd, supported in part by a grant from the Administration on Aging, on "Decline of the Aged,"⁸ it is noted that the aged are likely to become a dependent and marginal population, with the concentration of property rights in the hands of a small proportion of the population." Additionally, because the aged are prevented from remaining an active, integral part of our labor force due to physical constraints, legislative controls and even social values and attitudes, may lose their prestige from having no productive role in society. Hence, as strategic resources become more scarce, a case can be made that the superannuated, as well as children, are losing their valued position in society. As material resource control in the Twentieth Century has become a major determinant of prestige and "worth," we can assume the spiraling costs of institutional health care has further eroded the prestige and power of the elderly.

What are the costs to society at large? The extended family as a strong and meaningful social unit and source for inculcating individuals with cultural values is being undermined. And individuals have a dread of becoming older, less involved in society, less capable, often physically ill and thus "a burden" on their families in particular and society in general.

As Miss Helen Hayes and others who have worked on HHS programs have seen, if given a choice of whether to stay in the home with adequate therapy and maintenance care, or to move to an institutional setting, most elderly embrace the former. Miss Hayes' testimony before your committee, based on her experience working on the public television documentary "No Place Like Home," highlights the frustrations, feelings of helplessness, guilt, and depression felt by both the elderly and their families as the inevitable aging process creates stress. Because aging individuals cannot attend to all the tasks of running a home and may become incapacitated to varying degrees because of poor health, we must create a flexible needs-oriented HHS system to respond to these facts of life.

Trying to overhaul and rectify our current health care system without viable alternatives would probably be futile, a waste of time and money. Similarly, laying blame on one particular source for the "System's" malaise would not only be foolhardy, but unnecessary. The "System's" components, from health care professionals and private institutions to government subsidized programs and regulatory agencies, are inexorably intertwined creating dependencies and complexities. The hard facts of an aging population (30 million over 65 by 1990) with extended life expectancy (69.5 for men and 77.5 for women)⁹

make the search for immediate solutions critical. However, a few points should be noted with regard to the present "System."

The inadequacy of health care cited earlier is not a function of fewer professional healers in the United States. To wit, the number of physicians rose by 23 percent in the Seventies and will balloon 37 percent to about 400,000 in the Eighties. Yet increased availability of professionals does not seem to have a Supply Side economic relationship to costs of services. Some look at the average physician's salary (in the \$80,000 bracket) and assume that professional fees are the cause for the rise in health care costs. Physicians counter that their fees-for-service represent only 20 percent of the total health care package. Doctors, they assert, also are victims of inflated costs. They cite pay demands of nurses and support staff, the malpractice crisis of 1975 (when insurance rates in some States rose by 500 percent), costs of processing insurance forms and other inflationary factors as necessitating fee increases.

Other critics point to the American Medical Association, the American Hospital Association and other health-related associations, that spend many thousands of dollars each year on legislative advocacy and public relations to influence lawmakers' decisions and favorable public opinion. Nevertheless, the increase in physician fees and hospital charges

makes justification of alternative Home Care Services possible to accept. With respect to hospitals, their appeals are the enormous capitalization costs, from real estate to advanced technology, required to establish an institution. Even so, hospitals are Big Business regardless of whether their investment stems from private, public, or governmental services and beyond patient care lie strategies to control a greater share of the health care market. If institutionalization of the sick were not a profitable business, it is doubtful that hospital corporations in this country would be spending more than \$150,000 per bed to acquire facilities in the sunbelt region.¹⁰

STATE OF THE ART OF HHS IN AMERICA/1981

According to the recent statement of Eleanor Chelimsky, director of the Institute for Program Evaluation, to your committee, there is an unmet need for home health care in this country.¹¹ She reported with up to 2.7 million people in need of expanded services, the Congressional Budget Office in a recent study estimates only 300,000 to 500,000 were being given such services.¹² In fact, while the studies on this topic prepared by the Government Accounting Office may not be projectable to the total geriatric population, findings indicate that between 10 and 22 percent of the elderly, 65 years and older, in certain areas or cities were not receiving

all the homemaker/chore and personal care services they need.¹³ (In the State of Ohio, State HHC agencies estimate a six to eight month waiting period for homemaking services.)

Moreover, the Institute for Program Evaluation study cited the following shortcomings in the existing HHC system: it is limited by restrictions on eligibility and service coverage, access problems in some areas, and lack of information on the types of services available. This results in some elderly going without care or seeking institutional care as an alternative. Additionally, the study mentioned the present system's reimbursement process lacks incentives to minimize costs and it finds the provision of services and funding to be fragmented, monitoring service use difficult, and data management not always effective.

The problems with our HHS system as it stands today, of course, are too complicated and involved to be fully discussed here. What I want to focus our attention on is the great potential for resolving many of the problems associated with contemporary health care through a burgeoning new industry Home Health Services.

EMBRYONIC INDUSTRY ENTERS RAPID GROWTH PHASE

What was once considered old fashioned in healthcare, doctors making house calls, midwives, caring for grandmother in the home,

churches bringing meals to sick members of the parish, is on the comeback in America. Only today the services and products of HHS are being provided by State agencies, nursing homes, hospital outpatient programs, federally sponsored projects, individuals, churches and private industry. Since the committee has heard excellent testimony from representatives from most of the former delivery groups, I have deliberately chosen to focus my remarks on the private industry segment of the HHS market. As indicated by my professional background and experience, I have considerable expertise in this area and an interest in seeing it share in the responsibility for improving our nation's health system.

Basically HHS, from an industry analysis, is divided into three major market segments, or general categories, based on product/service concentration. The first segment is largely labor intensive consisting today of homemaker, therapist, nursing agency (such as Upjohn Homemakers) and medical service. Tomorrow we will see more physicians and nurses in the home. The second is durable medical equipment (DME) commonly known as sickroom supplies which includes companies which manufacture, sell, rent or lease equipment such as wheelchairs, hospital beds, crutches, etc. And finally, there is the "high tech" segment which includes companies which manufacture, sell or deliver advanced diagnostic, therapeutic and monitoring equipment for use in the home. Some examples of this industry include

respiratory therapy for cardio-pulmonary disease patients, kidney dialysis, parenteral nutrition and chemotherapy equipment and service companies.

The collective social, economic and political climate surrounding health care today points to a quantum leap in growth for these services and equipment represented by the private HHS industry in the next two decades. An increasing geriatric population (12-13 percent of the total population) of approximately 30 million by 1990¹⁴ with a concomitant increase in political clout, disease-causing environmental pollution, government requirements to develop cost effective programs which encourage self sufficiency, less taxation and less government in general, a perilously over-extended Social Security coffer, and increased social consciousness with respect to the needs of the aged are tantamount to placing a welcome mat out to the concept of HHS.

In 1980 Federal HHS costs amounted to \$750 million, over 12 times as much as they did a dozen years ago but still less than two percent of the total Medicare program outlay. With passage of S.234, the shift toward greater HHS at lower costs will set a new trend in health in America. Industry analysts are estimateing a 30-40 percent growth per year for the high tech HHS segment alone. A recent article in Venture (October, 1981) elaborates on the economic rationale for an upswing in HHS development:

"As advances in technology and equipment open the possibility of treating a variety of diseases in the home, and as hospitalization costs rise, the economics of home health care will beckon more companies to join the fray. Whereas the average daily cost of a hospital stay in 1980 was \$202 or \$73,000 a year, the average cost of home health care in the same period was only \$54 a day, or \$19,700 a year according to figures published in the Journal of the American Medical Association."¹⁵

However, the surface has only been scratched in terms of the range of services and products that will someday be available in the home. From physician controlled interactive computerized monitoring and diagnostic systems to retail purchasing and insurance coverage processing to complete life support technology, the future is bright for industry to help bring highly economical and humanistic professional health care into the home.

The time is not too distant when multi-divisional health care businesses with pharmaceutical, nonacute ambulatory transportation, medical claim processing, data banks for clinical record storing and networking between health care agencies, clinical therapy, outpatient facilities, professional rehabilitation in the home, nursing, homemaking and personal care and companionship will be serving national markets, and these are just the tip of the iceberg for what's to come. As John Scott Campbell, president and CEO of Medcare, Inc. and former co-founder of Homemakers (now Upjohn Home Health Care) reported in a recent article in Homecare (September/October, 1981):

"As the nation proceeds toward refinement of its health care delivery system, the increased use of homecare is the most significant factor, aside from technical medical changes, affecting our population relative to the improvement in health care."¹⁶

POSSIBLE SERIOUS CONSTRAINTS

Nonetheless, there is one hidden clause, one catch to prevent the vast resource door of private industry from swinging open to offer HHS with the resulting discrimination in spending for institutionalizing; that is government regulations with respect to private industry participation in Medicare/Medicaid programs. In order for the private sector to concentrate its R & D capital to develop full scale implementation of innovative HHS and products, the Federal Government must include profit-oriented industry in its Medicare/Medicaid reimbursement programs. Allowing the competitive forces of the free enterprise system full rein in HHS development will ensure that end-users get the quality and quantity of services they need. I know from personal experience in both public and private sector health care, the profit motivation, healthy competition and economy of scale of private industry coupled with a well conceptualized and

articulated legislative program can offer health care consumers a better product than would be available from solely nonprofit sources. The ability of private industry to create diversified delivery systems and services, its management and marketing expertise, and demonstrated experience in bringing to market quality services and products suggest to me that American industry would be an asset in realizing the goals of HHS.

I stress this viewpoint because of the aforementioned threat that special interests will gain an exclusivity agreement with government agencies for the delivery of HHS. Productivity has never been served by regulating competition. The best interests of society will be addressed when, and if, hospitals, nursing homes, government agencies and private industry work cooperatively under the auspices of proposed "The Community Health Services Act of 1981."

HHS: PROGNOSIS FOR THE FUTURE

We all recognize the importance of the home and hearth to people's sense of security and well being. It is thus only natural that people in the throes of drama (or trauma as the case may be) from the aging process or acute/chronic disease should yearn for the shelter of their homes. To maintain a

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healthy human body, mind and spirit, the home will be an essential setting for the delivery of health care in the future.

HHS services must, therefore, be expanded to include a variety of services along with monitoring, therapy and diagnosis. Homemaking, including food preparation, nutrition counseling, shopping and handling personal business of the client, companionship, social work counseling, even home maintenance are some of the areas which must be included in order to keep the individual functioning normally within the home environment.

Obviously there is much to be accomplished in the next few years to bring a HHS system "on line." I and my colleagues stand willing to volunteer our services in an advisory capacity to help your Committee or the offices of the Secretary of Health and Human Services with any of the imminently critical tasks requiring resolution. Some of the areas I feel should be addressed include:

- . Developing operational definitions of HHS including scope of services.
- . Developing a screening and referral system for potential clients of HHS services (and locating currently institutionalized patients that might qualify for home care).
- . Developing a cost/pricing index for HHS services and products.
- . Developing an interagency information network to facilitate placement, monitoring, evaluation of and research for HHS users.
- . Development of a public information program to create awareness of the HHS concept and promotion of its use and specific programs with the general public and targeted users.
- . Determination of optimum cost/feasibility aspects of various HHS program alternatives.

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- . Development of an equitable access policy for urban and rural areas.
- . Planning of reimbursement mechanisms and creative financing plans so costs of HHS can be shared between individuals, private insurance carriers and government programs.
- . Development of demonstration projects for concept evaluation and delivery system testing.

In concluding, Senator Hatch, I commend you and the Committee for sponsoring this greatly needed legislation. Its many features will improve the quality of life for all Americans. Change is ubiquitous in our world, yet one thing is certain, we all get old. Some of us, who contract diseases or lack financial resources, "look forward" with dread to experiencing our "Golden Years" in a situation more aptly described as a living hell.

S.234 has the potential of propelling our "ship of health" into calm waters. Carefully developed, this legislation will facilitate cost-effective HHS programs and services that help to restore the dignity and meaning to this final stage of human life. Further, "The Community Home Health Services Act of 1981" offers hope to every member of our society in addition to the aged, infirm, diseased and handicapped.

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NOTES

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2. Long-Term Care for the Aged and Disabled (Washington, D.C.: Congressional Budget Office, August 1977) p.x.
3. M.S. Freedland and C.E. Schneider, "National Health Expenditures: Short-Term Outlook and Long-Term Projections," Health Care Financing Review (Winter, 1981), p.106.
4. "Statement of Eleanor Chelimsky, Director, Institute for Program Evaluation Before the Committee On Labor and Human Resources, United States Senate on Expanded Home Health Care" (Washington, D.C., U.S. General Accounting Office, November, 1981) p.6.
5. K. Reiss, Federal Programs That Finance Home Health Care Services (Washington, D.C.: Congressional Research Service, March 1981), p.3
6. Medicare Home Health Services: A Difficult Program to Control, U.S. General Accounting Office, HRD-81-155, September 25, 1981, p.1
7. Ibid., p.6
8. Dowd, James J., "Decline of the Aged", Sociological Focus, (Vol. 14 No. 4., October 1981) pps 255-269.
9. 1981 Health Report (Washington, D.C.: U.S. Department of Health and Human Resources, December, 1981).
10. Whitney, D., "An Ill Wind Blows: The Escalating Costs of Financing Health Care...", TWA Ambassador, (October, 1981), p.28.
11. "Statement of Eleanor Chelimsky...", "Op. Cit.", p.7.
12. Ibid., p.7.
13. Ibid., p.8.
14. Source: FHH Review
15. Farrell, David, "Hospital Care At Home", Venture (October 1981), p.56.
16. "Acquisitions, Franchise Program Mark Beginning of Planned Medicare, Inc. Growth," Homecare (September/October, 1981, pps. 148-149.



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TESTIMONY PREPARED BY
THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES
FOR HEARINGS ON
S. 234, THE COMMUNITY HOME HEALTH SERVICES ACT OF 1981,
BEFORE
THE SENATE LABOR AND HUMAN RESOURCES COMMITTEE
NOVEMBER 20, 1981

The Catholic Health Association appreciates this opportunity to offer its views and recommendations on S. 234, "The Community Home Health Services Act of 1981". The Association commends the Chairman for his interest in and support for the expansion of home health care, a service which the Association feels is vital in the effective delivery of health care to the elderly and the disabled in the United States today.

The Catholic Health Association (CHA), established in 1915, is an association of not-for-profit hospitals and nursing homes, sponsored by religious orders and dioceses of the Catholic Church. As a national association, it represents 633 member hospitals

Representing more than 800 hospitals and long-term care facilities nationwide.

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and 260 long-term care facilities. Currently 114 (18%) of our hospitals and 17 (7%) of our nursing homes are certified by the Medicare program to provide home care to their patient populations and each year those numbers are growing.

Catholic health care facilities have long been dedicated to providing health care services whenever and wherever people are in need. The provision of health care to the homebound elderly and disabled is a natural extension of that mission.

While most of the home care departments in Catholic health facilities have been established for an average of five years, several have been delivering care in the home for many decades. In a recent Association survey of its home care departments, a central theme emerged as the major impetus for establishing a home care department in the facility. That theme was the provision of a more complete, patient-centered care package in the home, helping to restore a measure of independence, self-reliance and normal family living. In the words of Sister Brigida Cassidy, CSJ, home health care program director of St. Mary's Hospital, Minneapolis, Minnesota, their program was designed to stress "continuity, coordination and comprehensiveness." Many facilities responded that there was clear demonstration of community need, particularly in areas where there was a large, elderly population, many of whom were isolated, in poor health and experiencing financial difficulties yet who did not wish to enter a nursing home. Home health care, it was felt, would respect the elderly person's wishes in this regard, and meet the medical, social, spiritual

and emotional needs of the patient within the familiar surrounding of home, family and friends.

At the present time, community-based home health care services across the nation are highly fragmented and often insufficient to meet the needs of those they are designed to serve. As a result, many who now need non-institutional health care are not receiving it. S. 234 will allow hospitals and nursing homes presently certified to care for Medicare/Medicaid patients in the facility to extend their program of services to this patient population into the home. The extended coverage and added services (i.e. transportation, homemaker and home health aide) provided in S. 234 will also enable more of our elderly and disabled citizens to receive a more comprehensive treatment package in their homes and will allow many others to return from hospitals and nursing homes to their places of residence. S. 234 will thus help to alleviate the fragmentation earlier referenced by enabling hospitals to assume overall responsibility for a program of home care. In addition, the removal of the agency certification requirements and the expansion of benefits will contribute to overcoming the insufficiency of services earlier referenced. By making these programs more cohesive and increasing the availability of home health services, accessibility to needed home health care is greatly enhanced.

While the delivery of health care in the home has occurred for some time, it has only recently begun to receive recognition as a distinct service component of the health care field. It

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is now promoted as (1) a more cost-effective means for the delivery of care; (2) an alternative to institutional care; (3) a way in which to avoid inappropriate inpatient stays; and (4) for humanitarian reasons. The Catholic Health Association would like to offer its general perceptions with regard to each of the rationales presently offered.

COST-EFFECTIVENESS

There are many who say that home health care is a more cost-effective means of providing health care services. That assertion has frequently been read to mean that home health care is less expensive than institutional care and therefore may save the government a substantial outlay of funds for federal beneficiaries. The Catholic Health Association cautions that concentration on this rationale as a means to promote and expand home health care benefits and services could be misleading. At the present time, it still remains to be seen whether home health care is, in fact, a more cost-effective means of providing health care to the elderly and disabled. Under some circumstances, it may be the least expensive form of health care delivery but that depends upon the medical and social needs of the individual. For that patient who prefers to remain at home and needs only one or two services which can be provided in the home, home health care is likely to be cost-effective and should be the delivery of choice. However, it must be recognized that for those patients who require an intensity of services over a length of time, the

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cost/benefit of home health care is likely to be lost.

Increased family support, community involvement and the use of volunteers can help to make home health care cost-effective. A recent General Accounting Office report recommended that the use of home health aides in assisting patients with personal care could be substantially reduced with increased participation by the patient's family and/or friends in the care process. Family member support can and should be solicited with an orientation and training program made available. Taking an active part in the care of a loved one has been a meaningful experience for many. Often family members go on to become volunteers for others in need. Volunteers can be as much a part of the success of any program as are the professional staff. The impetus provided by the Reagan Administration in generating enthusiasm and support for voluntarism should certainly stimulate the use of volunteers in home care programs. An active volunteer recruiting and training program would encourage community involvement as well as help defray the cost of the service. Finally, community involvement can facilitate the development of appropriate program plans and goals, case-finding and networking.

ALTERNATIVE TO INSTITUTIONAL CARE

Home health care services are a vital part of the continuum of health care services. It is provided to those patients whose medical and social needs can be met by services in the home. Without this option many patients must have those needs met in

an institution. The availability of home health care thus prevents unnecessary institutionalization.

Its availability can preclude a premature or unnecessary admission to an institution, whether that be to a hospital or a nursing home. It can serve to avoid a readmission that may be due to the patient's noncompliance with the prescribed medical regimen. The home care professional is in a position to monitor and supervise the patient who is under the care of a physician on an intermittent office or home basis. The home care nurse can often augment the physician's treatment through the provision of professional observations and support. The timely provision of this care can stop deterioration and eliminate the need for institutional services.

Section Four of S.234 defines home health services as including any health services which are provided to an individual in the home and which are provided as an "alternative to institutional care". The Catholic Health Association feels that some elaboration on the definition is necessary to avoid misunderstanding. A service which is an alternative to institutional care should not be provided solely to save government monies. There are times when the elderly and disabled do require appropriate institutional services. Home health care should focus on the individual medical and social needs of the patient involved. A service provided should be the prescribed care appropriate to individual need, whether that is institutional care or care provided in the home.

By changing the reimbursement structure, the federal

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government and now S. 234 is recognizing that home health care is a vital part of the continuum of care. Such restructuring will work toward removing the institutional bias inherent in both government and private insurance plans against this mode of health care delivery.

AVOIDANCE OF INAPPROPRIATE INPATIENT STAYS

In those areas with large elderly populations and limited nursing home space, hospitals are often forced to retain their aged patients in acute care beds because no alternative placement is available. Home health care can promote cost-effective utilization of overburdened hospital and long-term care facility services. It can facilitate the early discharge of elderly patients to their homes, thus providing more appropriate care to the clients and allowing the facilities to make more effective use of their services. S. 234, which facilitates the development by hospitals of home care programs will go far in alleviating the problem presented by a large elderly population unnecessarily occupying acute care beds.

HUMANITARIAN RATIONALE

The provision of health care in an individual's home affirms a basic concept: people are happier in familiar surroundings and happiness promotes good health. Studies have shown that non-institutional care has a positive psychological effect on patients and may even prolong life. The majority of the elderly

and disabled, when asked, would prefer to remain in their homes and communities and out of institutions.

In any structured environment, individual freedom is limited and subject to routine. Institutional care by its very nature promotes dependency. This lack of control over one's environment can have a certain dehumanizing effect. It works counter to the goal of increasing independence and rehabilitation. Unnecessary and/or prolonged institutionalization tends to decrease the chances that the patient will return to the community.

The goal of any home health care program should be to help people remain in their communities in the best possible state of health and at a maximum level of independence. Our goal as a society should be to strive to make this a reality.

The Catholic Health Association and its constituency supports wholeheartedly the concept of the dignity and the worth of the individual. Home health care contributes to that dignity and worth by enhancing the quality of life while not reducing the quality care.

The Catholic Health Association would like to suggest certain modifications to the Community Home Health Services Act of 1981 and would like the Chairman to consider the following proposals.

\$ 3 GRANTS AND CONTRACTS FOR HOME HEALTH SERVICES AND TRAINING

Most communities in this country provide some type of home care. In many cases, however, programs in existence are either inadequate to meet the needs of the community or focus

on a particular type of care, i.e. hospice care. Section 3 of S. 234 would provide grants and contracts to facilities in communities with no home care program. The Catholic Health Association recommends a reconsideration of this provision. Priority in the awarding of grants and contracts should be given to communities with an inadequate rather than a total absence of home care services. Such a move would overcome the problem created in those instances where a program has a single distinct focus. In addition, it may cost less to expand an existing program rather than to establish a new one. A community will be better served with a more comprehensive rather than a limited program and the government will not have as great an outlay of funds.

While CHA is certainly supportive of efforts to expand home health care programs on a nationwide basis, we feel it is important to express our opposition to the inclusion of proprietary organizations in the provision of funds for establishing and operating such programs. Generally speaking, for-profit entities have ready access to sources of capital. Program financing is not as easily available to nonprofit organizations. While philanthropy was a major source of funding for nonprofit facilities in the past, few not-for-profit hospitals and nursing homes are fortunate enough today to be able to rely heavily on that source of revenue. Consequently, the not-for-profit facility, experiencing difficulty in capital markets and with little or no philanthropy available, finds itself hampered in the establish-

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ment of new services within the facility. To the extent that S. 234 provides federal grants to for-profit home care organizations, it further contributes to the disadvantage under which the not-for-profit health care facility presently operates.

The Catholic Health Association is pleased that S. 234 confronts the issue of the potential for fraud and abuse in the delivery of home care services. Unfortunately, such occurrences in this sector of the health care delivery system in the past have created the need for some sort of safeguard. However, in addition to instituting safeguards to prevent fraud and abuse, CHA would like to see some mechanism for assuring standards of high quality of care in the actual delivery of home care services. With individual professionals and para-professionals operating at distances from their home offices, it is often difficult to assess quality or attempt accountability. Some standard must be set. They could be in the form of a medical and social assessment by the physician and appropriate professional staff or those services provided in the home by the hospital could be subject to standards set forth by the Joint Commission on the Accreditation of Hospitals. Whatever the final criteria, this is an area of concern to the Association and should not be ignored in the rush to extend benefits and services.

S4 MEDICARE AND MEDICAID PROVISIONS

The CHA is supportive of the changes made in the Medicare and Medicaid provision that adds "nursing services for chronic

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and acute care". The recognition that it is chronic care that the elderly most often require is a positive move away from the medical model so often employed when determining the needs of this population.

We would like to recommend, however, that a provision for rehabilitative services be included. The continuation of rehabilitation therapy begun in the hospital is a vital factor in the recovery process and for the prevention of further disability. It may be that by providing these services, the patient will be able to recoup some lost ability and return to a maximum level of independent living. It can also frequently eliminate and certainly delay the need to enter a nursing home. Perhaps this concept can be included in the clearer, broader definition of "alternative to institutional care".

LONG-TERM CARE FACILITIES AS PROVIDERS OF CARE

The Catholic Health Association recommends that long-term care facilities be included in the Section Four definition of home health service providers and that they be able to participate in the demonstration projects set forth in the same section. These facilities have a long history of caring for the elderly and disabled and are well aware of the psycho-social problems attendant the chronically ill. It would be an appropriate extension of their provision of services to offer care in the patient's home.

The Catholic Health Association thanks the Chairman for

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this opportunity to present its views on home health care services and "The Community Home Health Services Act of 1981". We reiterate our support of the Chairman for his interest in home care services and would be pleased to provide any assistance to assure passage of this important initiative.



The American Occupational Therapy Association, Inc.

Mae D. Hightower-Vandamm

PRESIDENT

James J. Garibaldi

EXECUTIVE DIRECTOR

STATEMENT OF

THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, INC.

ON

S. 234, COMMUNITY HOME HEALTH
SERVICES ACT OF 1981

SUBMITTED IN CONJUNCTION WITH
HEARINGS BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES

U.S. SENATE

NOVEMBER 10, 1981

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The American Occupational Therapy Association, Inc. (AOTA) appreciates the opportunity to submit this testimony on S. 234, Community Home Health Services Act of 1981, in conjunction with hearings held before the Committee on Labor and Human Resources on November 10, 1981.

AOTA was formed in 1917 and represents over 33,000 occupational therapists, certified occupational therapy assistants, and students of occupational therapy. The Association manages the national certification system for occupational therapists; it accredits occupational therapy educational programs; it has developed and directs a system of continuing education opportunities for therapists throughout the country; and it has established and monitors professional standards of practice and ethics. The Association also serves as a strong advocate and public voice for people of all ages who are physically, mentally, or developmentally disabled.

Introduction

AOTA submitted testimony on a previous draft of S. 234 during hearings held on March 4, 1981 before the Committee on Labor and Human Resources. In that testimony, AOTA strongly supported the initiatives of S. 234 in improving the access to home health care for millions of elderly and disabled citizens. We continue our strong support for improved and expanded home health care services and we continue to support S. 234 as redrafted. However, changes in the Medicare provisions governing home health care services made by the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) force us to amend our previous testimony somewhat.

Specifically, P.L. 97-35 repealed that part of the Medicare law which established occupational therapy as a primary or qualifying service for home health eligibility. Under present law, Medicare patients may continue to receive occupational therapy services under the home health benefit after the patient's need for qualifying services (nursing, physical therapy, speech therapy)

has ended, but the need for occupational therapy services alone will not qualify the patient for Medicare home health services. The repeal of the occupational therapy qualifying provision was made only six months after its enactment into law by the Omnibus Reconciliation Act of 1980 (P.L. 96-499) and was based on specious cost estimates. While we continue to strongly support S. 234, we feel that occupational therapy as a primary or qualifying service is an integral part of any home health care program and that occupational therapy should be reestablished as a qualifying service.

The Practice of Occupational Therapy

Occupational therapy is a health profession which has its foundation in the medical management of patients. The service is provided to persons of all ages who are physically, psychologically, or developmentally disabled. It includes the functional evaluation and treatment of several different types of patients including those suffering from strokes, heart attacks, arthritis, diabetes, serious burns, spinal cord injuries, and psychiatric disorders. The purpose of occupational therapy is to direct these patients to achieve a maximum level of independent living by developing those capacities which remain after disease, accident, or deformity.

The occupational therapist's initial focus is on treating that pathology or those impaired functions which preclude independence and productivity.

Occupational therapists evaluate and treat:

- Impaired muscle strength, range of motion, and physical endurance
- Impaired eye-motor coordination, sensory integration, and motor planning
- Impaired concentration, attention span, thought organization, and problem solving
- Impaired visual-spatial relationships, body schema, figure-ground discrimination

Occupational therapists also seek to inhibit muscle atrophy, minimize deformity, and increase pain tolerance. They are also vitally concerned with the psychological impairments which frequently result from the patient's illness or trauma.

The treatment modalities used by occupational therapists are those which, in addition to reducing specific pathology or impairment, will simultaneously help the patient learn to apply the newly restored or impaired function to the demands of daily living, thus speeding recovery and an early return to a more independent life.

In summary, occupational therapists use selected rehabilitative tasks to reduce specific pathology or impairment and help individuals achieve independence.

Occupational therapists provide services in rehabilitation centers, through home health agencies, in acute care hospitals, long and short-term psychiatric facilities, skilled nursing facilities, outpatient clinics, community mental health centers, tuberculosis hospitals, day care centers, and private and public school systems.

Occupational Therapists, Registered (OTRs) carry professional and administrative responsibilities for occupational therapy programs and services. They are responsible for evaluating patients, developing program goals, working with patients to achieve these goals, and documenting progress. Certified Occupational Therapy Assistants (COTAs), working under the supervision of OTRs, assist in patient treatment and total program implementation.

Occupational Therapy As A Primary Home Health Service

Occupational therapy is an important part of the home health care provided to many Medicare beneficiaries. It is especially necessary for individuals who are victims of strokes, heart attacks, diabetes, multiple sclerosis or spinal cord injury, who are disabled by severe arthritis, or who have suffered physical injury as a result of a fall or some other accident.

Occupational therapy focuses on increasing the individual patient's functional level. The application of this service often plays a critical role in ensuring the person's full recovery, the prevention of further disability, and a successful readjustment to the home and community environment. The occupational therapist will establish an activity program designed to increase the patient's level of physical function. The therapist will also teach the patient, and those family members or others who will care for the patient, compensatory techniques which permit the patient to function more independently with feeding, dressing, and personal hygiene activities. The therapist will also make splints and self-help devices which either protect against joint deterioration, e.g. with an arthritic patient, or make the individual more independent, e.g. by providing stability of the wrist joint which will allow a person with severe wrist deterioration to use their remaining hand function. Finally, the therapist will recommend changes in the physical environment of the home to promote increased patient independence under the safest conditions possible.

Under current Medicare law (as amended by P.L. 97-35, Omnibus Budget Reconciliation Act of 1981) occupational therapy services are covered by Medicare only if the patient is qualified to receive home health services by the need for nursing, physical therapy or speech pathology. This restriction on occupational therapy as a primary or qualifying service contradicts the mandates of quality health care and contributes to the unnecessary spiraling of health care costs. As noted above, the need for other services are required prior to the coverage of occupational therapy, yet in many instances only occupational therapy is needed to meet the medical needs of beneficiaries covered under the Medicare home health benefit. Specific patient conditions where only occupational therapy might be needed include the following:

- The patient who has been ambulatory and functioning independently in her home calls her physician because she is no longer able to walk safely

and has fallen several times. The physician determines that she has decreased knee and ankle motion bilaterally due to accelerated osteoarthritic changes. The physician orders a home health occupational therapist to design and fabricate night resting splints to increase knee and ankle motion and prevent further deformity. Without these splints, the joints will permanently lose range of motion, and the patient may never walk again. The physician's alternative to occupational therapy in the home is admitting the patient to a hospital or transporting her by ambulance to the occupational therapy outpatient department of the hospital.

- A person who has a brainstem stroke often experiences generalized weakness, inability to swallow, and impaired oral function. After the physician evaluates the patient, the occupational therapist uses specific treatment techniques to control the drooling and facilitates swallowing. The occupational therapist also works with the family members to teach them ways of assisting the patient to improve swallowing skills. Again, only the occupational therapist is needed to decide the appropriate treatment program or determine the length of treatment required.

- The diabetic wheelchair-bound patient with bilateral above-knee amputation, partial blindness, and decreased sensation in her hands due to diabetic neuropathy has been discharged from home health physical therapy soon after she was independent in wheelchair transfer techniques. She needs the continued services of an occupational therapist to teach her an acute awareness of her sensory deficits and compensatory techniques to overcome her partial blindness and poor hand sensation. Without the occupational therapy program, complications such as accidental burns in the kitchen and decubiti can easily occur.

- The homebound patient with chronic lung disease and subsequent weakness, decreased endurance, and a continuous need for oxygen has difficulty performing daily functional activities. She is unable to pace her activities

with her limited breathing capacity, and her physician has ordered occupational therapy to see if an energy conservation program will allow the patient to perform the necessary daily activities to remain at home and avoid nursing home placement.

● The patient with a long history of multiple sclerosis is experiencing increased difficulty with coordination due to spasticity and is no longer able to feed herself. She needs an occupational therapist to decide whether adaptive equipment would allow her to regain independence. Only the occupational therapist is skilled in assessing and providing this type of equipment, and no other service is necessary.

It should be noted that occupational therapy is reimbursable under Medicare when provided to inpatients in hospitals and skilled nursing facilities, outpatients in clinics attached to approved hospitals or in comprehensive outpatient rehabilitation facilities and to outpatients when provided "incident to a physician's professional service," as well as to recipients of home health care if the patient is qualified by the need for nursing, physical therapy or speech pathology services.

Cost Consideration

Crucial to any discussion of improving home health benefits supported by the Federal government is the impact on the Federal budget. The Association believes that S. 234 represents a significant, necessary and cost effective improvement in the Medicare program, and that the reestablishment of occupational therapy as a primary service is an integral part of the improvements made. We will first comment on the cost impact of improving home health benefits in general, and then comment on the cost impact of including occupational therapy as a primary service.

Any cost estimates assigned to the improvements in home health care in S. 234 must be counterbalanced with cost savings from reducing patients' length of stay in hospitals and from reducing the utilization of long term

care services. Further, the increases in the cost of the Medicare home health benefit over the past several years must also be seen as having had a dampening effect on the rate of increase in hospital and nursing home costs. It is not reasonable to prepare a cost-estimate on present or expanded home health care without taking into consideration the extent to which home health care can be a cost effective substitute for institutionalization. Although more extensive studies and demonstration projects are needed to better calculate the cost-effectiveness of home health care, several recent reports are indicative of the potential savings by expanding home care.

In Maryland, the Blue Cross and Blue Shield plan recently reported that its home care program saved more than \$750,000 in hospital costs in 1980, with 666 patients saving an average of 11.4 inpatient days. A standard feature of locally underwritten contracts, the program provides benefits for medically necessary care (including occupational therapy) at home instead of in the hospital.

Similarly, the Arkansas Office on Aging in a June 1981 report evaluating its own in-home option, stated that it is cost-effective for government to support programs that retain clients in their own homes. According to the report, expenditures for the in-home program totalled over \$5 million for approximately 13,000 patients, while nursing home costs for 21,500 patients cost \$5,511 per patient, while home care cost \$406 per patient.

In addition, the delivery of services in the home immediately following a hospital stay frequently represents the most appropriate means of ensuring that the patient will make the necessary transition from the hospital setting to the home. The availability of home care greatly increases access to needed services for the elderly and disabled who might otherwise have to go without them or be hospitalized to receive them. Home care is also a more humane form of treatment of individuals who, as long as they receive certain services, do not need to be institutionalized. In fact, evidence indicates

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that those patients receiving home health care instead of currently available services live longer, are more content, and improve their mental functioning. These positive patient outcomes, taken in conjunction with the cost-effectiveness of home care, are particularly persuasive in the support of expanding the Medicare home health benefits.

AOTA is particularly concerned about the cost estimates that have been, and continue to be, applied to the establishment of occupational therapy as a primary service under the Medicare home health benefit. Cost estimates developed in 1979 by the Department of Health, Education and Welfare (now Health and Human Services) were, in our opinion, grossly invalid and far in excess of reasonable estimates. Yet, it is the 1979 DHEW estimates (as adjusted) that are still being used for legislative and budget impact estimates. These erroneous original estimates must be rejected and more realistic projections calculated prior to any future discussion of amending the Medicare occupational therapy home health benefit provisions.

In 1979, DHEW projected the increased cost in fiscal year 1981 for occupational therapy being made a primary service by the following method. It was determined that since these were approximately one-half as many occupational therapists as there were physical therapists, the cost for home health occupational therapy would be approximately one-half that for physical therapy. The cost in fiscal year 1981 for physical therapy was projected to be \$80 million, one-half of that was taken to equal \$40 million and an adjustment was made allowing for delayed demand reaction resulting in a projection for increased occupational therapy cost in fiscal year 1981 of \$28 million. It is this \$28 million (as adjusted for inflation) that is still being used in cost estimates. Several points should be made. The initial projected figure represented total projected occupational therapy costs in fiscal year 1981 and was not adjusted to account for the cost of occupational therapy that would have been provided under the Medicare provisions in 1979. Further, the

cost estimate representing a three-fold increase in occupational therapy home health services in the span of one year is totally unreasonable and disregards significant aspects of the occupational therapy manpower situation including the numbers of working therapists, the capabilities of the educational system, employment patterns of occupational therapists, and reasonable expectations of increased utilization. Regardless of the inaccurate cost estimates, Congress decided that occupational therapy was important enough to be a primary qualifying service under the Medicare home health benefit and included such an amendment in the Omnibus Reconciliation Act of 1980, including a cost estimate for fiscal year 1982 of \$35 million.

In early 1981, it was proposed by the Administration to repeal the entire occupational therapy amendment to effect savings in fiscal year 1982 of \$35 million. As noted above, the cost estimates were highly inflated, so the supposed savings would be equally inflated. In a House/Senate conference on the Omnibus Reconciliation Act of 1981, it was agreed to repeal only part of the occupational therapy amendment such that the need for occupational therapy alone will not qualify a patient for home health benefits, but once a patient is qualified, occupational therapy services may remain in the home after the need for qualifying services (nursing, physical therapy and speech therapy) has ended. The projected "savings" by this amendment was calculated to be \$23 million in fiscal year 1982.

Thus, it appears that the cost to reestablish occupational therapy as a primary service would be \$23 million. As noted above, **however, the \$23 estimate** is based on inaccurate estimates originally developed in 1979. AOTA has recently developed cost estimates that are far more realistic and are based on trends in the cost of the Medicare home health program. In applying a very liberal 25% increase in utilization in one year (very unlikely), and assuming that the ordering of other covered services (such as home health aides) will be proportional to that at present, the total maximum increased cost in the

home health program would be just under \$11 million. Further, these cost estimates do not take into account the savings represented by the offset of accompanying reductions in institutional costs. If occupational therapy services are not covered in the home, the Medicare beneficiary may be placed in the more expensive hospital or nursing home setting where treatment can be provided on a covered basis. Programs cited earlier such as those in Maryland and Arkansas give ample evidence of potential savings by expanding home health services, including occupational therapy.

Summary

The statistics on the rapid increase in health care costs and the increase in the number of Medicare patients are well known. In the year ending March 1981, the nation spent \$255 billion on health care, 9.4% of the GNP, with approximately 30% of that total spent on health care for the aged. The nation spent \$99.6 billion, about 46% of all health costs, on hospital care in 1980, representing a 16.2% increase over 1979. The average medical bill for a person over 65 was over \$2000 in 1978, with less than half that for those under 65. In addition, the number of persons over 65 is growing. The elderly population grew from 9.7% of the population in 1970 to 11.1% in 1980, and is expected to be over 20% by the year 2030.

The present system is skewed toward expensive institutional use due to coverage requirements. Without adequate coverage of alternative settings, such as home care, it is logical to assume that hospital and nursing home costs will continue to rapidly escalate. The broadening of home health benefits will not be a panacea for the future financial pressures on the Medicare and Medicaid programs, but the passage of S. 234 will remove some of the institutional bias built into the present system. The issue is not whether the Medicare beneficiary will receive health care, but rather whether the beneficiary will have a viable option to high-cost institutional care.

The members of The American Occupational Therapy Association support S. 234 and encourage the increased accessibility to home health services, including occupational therapy.


AMERICAN HOSPITAL ASSOCIATION

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November 24, 1981

 The Honorable Orrin G. Hatch
 United States Senate
 Washington, DC 20510

Dear Senator Hatch

On behalf of the American Hospital Association, which represents more than 6,100 member hospitals and health care institutions, including more than 510 hospitals which provide home health services, I would like to present our views on revisions to S.234, the Community Home Health Services Act of 1981. On March 18, 1981 we submitted testimony to your Committee in support of S.234 as originally introduced and recommended several modifications. Our comments and suggestions in this letter will be confined to certain proposed modifications in the bill and to an expansion of our previous comments on the provision included in the original bill which would permit Medicare-certified nonprofit hospitals to provide home health services.

Hospital Providers of Home Health Services

Section 4 of the proposal would amend the Medicare program by expanding the definition of covered home health services to include certain services provided in an individual's home by a Medicare-certified home health agency or a Medicare-certified nonprofit hospital. This provision would remove the separate certification requirement for hospitals providers of home health services by permitting those which meet the Medicare hospital conditions of participation to provide home health care without establishing a separately certified home health agency. We strongly reaffirm our support of this provision because elimination of the separate certification requirement for hospital-based home health agencies would be a necessary stimulus for more hospitals to provide home health services, a principal goal of S.234.

Currently, hospitals which provide home health services under the Medicare program are subject to two sets of Medicare certification requirements--the conditions of participation for hospitals and the conditions of participation for home health agencies. Past experience indicates that such multiple certification requirements frequently result in additional administrative burdens and duplicative recordkeeping requirements for hospitals, and increase costs without improving the quality of care.

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Moreover, the imposition of separate certification requirements for hospital providers of home health services tends to limit the availability of home health services, particularly in rural areas. Of the 300 counties in the United States which are not served by Medicare certified home health agencies, as reported to us by the Department of Health and Human Services, most are in rural areas. Many rural hospitals located in or near these areas are unable to provide needed home health services because limited operating budgets prevent them from meeting the additional administrative expense. Therefore, the ability of rural hospitals to provide home health services would be greatly improved by the enactment of the provision to remove the separate certification requirement.

In addition to avoiding unnecessary administrative costs and increasing the availability of home health services, the quality, coordination, and continuity of hospital-based home care services would be improved if separate Medicare certification were eliminated for these programs. A hospital home health program would operate as any other department within the hospital, instead of as a separate entity with its own support systems and with less access to the hospital's resources. For example, inpatient records would be readily available and accessible to the hospital home health staff, making it easier to coordinate hospital and post-hospital care. Moreover, as part of the hospital team, the home care staff would be able to utilize the expertise of in-house staff regarding nursing care, patient education, nutrition plans, and other services.

Quality of care would be enhanced by a variety of mechanisms. The home care program, as a department, would be reviewed by hospital medical committees and quality assurance programs just as are other departments. And home care departments of hospitals accredited by the Joint Commission on Accreditation of Hospitals (JCAH) would continue to be surveyed under the JCAH standards for hospital-based home health programs, standards which, according to a recent General Accounting Office (GAO) report,¹ are more comprehensive and stronger than the Medicare certification requirements for home health agencies.

Finally, we believe that a home care program operating as an integral part of the hospital not only would increase physician involvement due to the accessibility of the home care staff, but also would result in cost savings as physicians gain confidence in the home care staff and discharge their patients earlier from the hospital. This would result in a more appropriate utilization of services.² Recent testimony presented before your Committee by the GAO indicated a reduction averaging 13.3 days in hospital lengths of stay as a result of home health services. Such a reduction in length of stay for inpatients has the potential of reducing case costs.

¹ Medicare Home Health Services: A Difficult Program to Control, U.S. General Accounting Office, HRD-81-155, September 25, 1981.

² Ibid.

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Covered services

Section 4 of the revised proposal would expand Medicare home health benefits through the addition of homemaker services, combine the functions of "homemakers" and "home health aides" into one definition, and establish identical requirements for both. These requirements would consist of 40 hours of clinical and 40 hours of classroom instruction, or equivalent training by work experience, testing, or licensure. We are concerned that the combining of the two functions through the establishment of identical personnel qualifications for homemakers and for home health aides may restrict the supply of homemakers and increase costs to the Medicare program.

Homemakers traditionally provide household services such as light housekeeping and the purchase and preparation of food. Home health aides provide more specialized personal care services such as assisting with moving, bathing, grooming, and exercising patients. While we agree that training programs for home health aides are necessary and appropriate to assure care of good quality, we question the necessity of mandating similar classroom and clinical instruction for homemakers. Personnel qualifications set at unnecessarily high levels often result in higher expenditures which do not improve the quality of care. Moreover, we feel the supply of homemakers could suffer, because some homemakers may be reluctant to participate in a training program not directly related to their functions. Therefore, we recommend that the two functions and qualifications be kept separate, with more appropriate training requirements established for each.

Tax Credit Provision

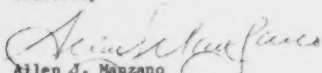
Section 5 of the revised proposal would amend the Internal Revenue Code to provide a tax credit of up to \$500 for individuals whose households include a dependent who is 65 years of age or older, has a medical condition expected to be of long duration or result in death, and could receive adequate care in the home setting. We support the intent of this provision because it would encourage families to provide home care for elderly dependents in need of medical care. One of the reasons given by families who choose institutionalization over in-home services for their elderly dependents is the lack of adequate financial resources.³ Such a tax credit would help offset the cost of keeping older relatives at home, thus reducing the likelihood of institutionalization. Moreover, any reduction in institutional placement has the potential of reducing overall health care costs.

³ "Long-Term Care for the Elderly and Disabled," Congressional Budget Office, February 1977.

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We wish to commend you for your efforts to encourage the development of home health programs as an alternative to institutionalization. We wholeheartedly support this objective and would be pleased to provide any further information or assistance that you might request.

Sincerely



Allen J. Manzano
Senior Vice President

fh

Statement of

The American Association of Homes for the Aging

on

S. 234

Community Home Health Services Act

Submitted to the

Committee on Labor and Human Resources

United States Senate

November 20, 1981

INTRODUCTION

The American Association of Homes for the Aging welcomes the opportunity to respond to the initiatives proposed in S. 234, the Community Home Health Services Act, which seeks to provide expanded coverage of home health services under the Medicare and Medicaid programs.

The American Association of Homes for the Aging (AAHA) represents non-profit homes, housing and health-related facilities, including nonprofit providers of skilled nursing and intermediate care. AAHA's 1,850 member homes, sponsored by religious, fraternal, civic, labor, government and other community organizations, serve nearly 300,000 elderly throughout the country.

An essential component of AAHA's philosophy is for a member home to be responsive to the needs of the larger community as well as its own community of residents. Four out of ten AAHA homes offer at least one outreach service to elderly persons in the community. Of these, three in five offer two or more services; twenty percent provide five or more outreach services, and twelve percent offer between six and ten services on a regular basis to the local community. Among these homes are a number which offer home health services. Therefore, the proposals in S. 234 are of great interest and concern to homes for the aging and to the elderly residents of the communities they serve.

AAHA supports the general concept behind the Community Home Health Services Act. We endorse provisions that would expand home care in underserved areas. Clearly, there is a need to find ways to make sure that the nation's elderly have a solid base of institutional, community-based and in-home services they can choose from when support is needed.

To this end, AAHA strongly recommends that S. 234 include a significant role for long term care facility-based home health services, in addition to

hospital-based services. There should also be recognition in the bill of the fact that home care may be appropriate for elderly with emotional and social as well as chronic or acute needs.

We should make every reasonable effort to help people remain in their own homes and in the community for as long as they want to be there. A vital part of that effort, then, should be to focus on the total needs of the individual and his or her environment; that is, to bring a total range of in-home services to the person in need. This is what AAHA homes strive to do for their residents and for the larger community of residents they serve through outreach programs such as home health care. These homes for the aging truly have become "homes without walls."

NEED FOR HOME HEALTH CARE

Many persons with serious physical or mental impairments and social needs require some sort of specialized care a home for the aging is best suited to provide. But with the elderly population, particularly those over 75, growing by several thousands every day, our nation must be making plans now to expand the quality and variety of care available to the growing numbers of those in need of services, including institutional and noninstitutional services.

Certainly, those whose needs can be met at home and who choose to remain there often will thrive better in their own familiar environments. There is concern, however, that the broad focus on comprehensive human needs will suffer if home health care programs concentrate exclusively on medical supports. A great variety of needs are encountered in in-home care, from the necessity for nutrition counseling, psychiatric counseling, transportation, physical therapy, or merely a friendly chat, to more traditional health services. For this reason, home health care should involve a variety of individuals, such as

physicians, nurses, therapists and social workers. Providers should train in-home aides to recognize and deal with a wide range of human problems they are likely to encounter during in-home visits.

For some elderly, in-home care, if made readily available, can prevent or delay the need for institutional care, reduce hospital readmissions or make earlier discharge from an institution possible, with resultant cost savings (although the welfare of the individual, not costs, should be the major concern here). For many others, however, we reiterate that the sophistication and frequency of care needed make facility-based care the best alternative, in terms of adequate care and in terms of costs of providing the necessary services.

NEED FOR INSTITUTIONAL CARE

It has been shown repeatedly that once older people become greatly impaired, the cost of in-home services can be far greater than the cost of institutional care. Moreover, in-home services may not be adequate to provide the round-the-clock medical, social and emotional supports needed by the chronically impaired. What home health can do is to prevent or postpone the larger costs of an extended illness or institutional stay. What it probably cannot do is lessen the need for institutional services.

Care must be taken that expanded home health is not marketed to the public in such a way as to create expectations for a dramatic decrease in long term health care costs. We estimate, as does the Department of Health and Human Services, that there are several times as many people just as in need of long term care who are not being served as there are individuals currently being served in nursing homes. Therefore, it is entirely possible, even probable, that rather than reducing long term care costs, the expansion of public coverage for home health might well attract a new population not now covered by

government programs. Even if an increase in home health care succeeds in freeing some nursing home beds now in use, there are many elderly not now being served at all who will be waiting for a vacancy.

NEED TO ELIMINATE BARRIERS
TO ADEQUATE, QUALITY IN-HOME CARE

In any effort to make health care more widely available, there is a need to eliminate the major barriers to adequate care the current system has fostered. Among these barriers are inadequate coverage by public programs and the resulting gaps in service, which S. 234 seeks to address; a lack of referrals to home care where it is available and would meet the person's needs; lack of public education about the choices of care (again, in the few areas where there are choices); too great an emphasis on meeting medical needs alone; and the failure to develop an adequate network of preventive, treatment and maintenance services.

In-home providers and, in fact, institutional providers, are hampered by reimbursement policies that consider it easier to deal with all care as either health or social services, but not both. Financing of long term care should ensure that all persons for whom such care is appropriate have timely access and entitlement to a complementary range of services to meet their health and social needs. Unfortunately, because of the public policy focus on acute care, this nation has thus far failed to develop an adequate system to make those assurances.

Our public programs of income maintenance, health care and social services have evolved mainly as separate categorical programs aimed at many different constituencies. The result has been that individuals who need services over any length of time frequently must shift from one provider to another and/or

one funding source to another, sometimes with services being interrupted needlessly (or dangerously). For other persons, even those in relatively good physical health, psychological and social problems are the major concerns; in many cases, they are not likely to find programs to help them.

SELECTIVELY LINKING FACILITY-BASED
PROGRAMS AND COMMUNITY HOME INITIATIVES

As stated above, we are pleased to note that the sponsors of S. 234 have recognized the merits of linking the capacity of facility-based programs with the delivery of community home services. The New York State program of "Homes without Walls" shows the tremendous advantages of such an approach. At the same time, while the linking of facility and community programs would be a positive step in policy, the question must be raised, "Which facilities?" As members of the committee may know, New York State has restricted which providers can be eligible for participation in the Homes without Walls program. This decision was a conscious one by the state legislature to lessen the risk of profiteering in human service delivery. The findings of the Moreland Act Commission in that state indicated that a number of for-profit enterprises delivering facility-based programs were substandard. The state did not want to replicate the neglect for quality in the demonstrations on home care.

While it is a sensitive subject, the facts indicate some facility-based programs are substandard. The facts suggest a correlation of inadequate attention to patient care with profiteering. In the consideration of this legislation, this committee should desire to reduce the risk of fraud and abuse and to promote the highest standards of care for recipients. Those goals may conflict with the opportunities given for any facility-based program to expand into home health care with the assistance of the new initiatives inspired by this legislation.

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We believe there may be reason to restrict the availability of the assistance provided in this legislation to nonprofit sponsors which have been established as bona fide community-responsive providers. At a minimum, the legislation should restrict acceptance of applications from facilities that have demonstrated repeated deficiencies in the provision of patient care services in the facility setting. We call for a conscious action by the committee to screen the poor providers out of the services field while providing incentives for the quality providers to expand. This is not market interference; this is wise public policy.

There is a clear need, then, in the home health field, for effective program management and recognition that home health programs may be susceptible to fraud and abuse. Regulations can be developed to guard against fraud, but they should be carefully designed in order not to handicap programs by denying eligibility to those who need services.

STRENGTHENING THE FAMILY'S ROLE

Any legislation and regulation should ensure, too, that government policies do not undermine the family's role in caring for the elderly. The most significant contributions to long term care services are made by family, friends, neighbors, church and community. We should support and enhance these contributions, not act unwittingly to displace them. The social and financial costs to the nation would be too high.

We support, therefore, the provision of S. 234 that would amend the 1954 Internal Revenue Code to provide a tax credit for households with eligible elderly dependents. Although the credit is a modest one, we believe it will help strengthen the ability of families to care for elderly relatives. Frequently, though, whether family care is available is not just a question

of money. There is evidence to show that children will go to great lengths to care for their elderly parents, in spite of financial and other hardships. The tax credit is a start, but it should be recognized that monetary incentives alone will not ensure that needed care is available or will be given.

Other supports of family involvement in long term care are needed, particularly now that so many families are headed by two-earner couples. AAHA supports consistent funding for adult day care and respite services to help these families.

It also should be noted that for many impaired elderly, being at home may not be the best solution. In addition to a tax credit for households with dependent elderly, AAHA supports amending the Internal Revenue Code to permit taxpayers to deduct Medicare supplemental insurance premiums and other payments made on behalf of relatives residing in specialized living arrangements. We also believe reimbursement policies should allow Medicare and Medicaid facilities and licensed social care facilities to offer adult day care and respite services as options to home health visits, where appropriate.

CONCLUSION

The American Association of Homes for the Aging believes that the concept of S. 234, to expand the scope and availability of home health services, is a laudable one. We stress, however, that such a system should be developed to complement, not replace, institutional care. AAHA further suggests that homes for the aging, a number of which already provide quality home health services in their communities, have demonstrated the ability of long term care facility-based home health providers to coordinate and develop stellar programs to promote, maintain and restore health and to minimize the efforts of illness, disability and social and emotional impairments. We strongly

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encourage the Congress, in its deliberations on S. 234, to include a significant role for long term care facility-based home health, as well as hospital-based home health, in the legislation.

AAHA appreciates the committee's attention to our suggestions, and we welcome the opportunity to discuss further any of these and other issues pertaining to long term care.

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DAC/bjc
11-23-81

*Fairfield County Respiratory Associates*4270 MAIN STREET
BRIDGEPORT, CONNECTICUT 06606

TELEPHONE (203) 371-0139

PILOT STUDY1977 - 1981 REPORTas prepared by John M. Zavatsky, Jr.
PRESIDENT

INTRO:

F.C.R.A. has been serving respiratory patients quality care in skilled nursing homes since August 1977. The goal of F.C.R.A. is to deliver optimum care to the patient in skilled nursing facilities at a reduced cost without transferring the patient to an acute care hospital. Hospital length of stays are extremely expensive due to the increase of technology in the facility. Without F.C.R.A.'s services, patients with respiratory care needs would be transferred to the neighboring hospitals. As a result, many patients are kept in a high cost, acute care hospital bed when the use of lower-cost facilities is indicated. The state is paying approximately 5 times the amount per day if the Medicaid patient is transferred and treated in an acute care hospital, (all costs included) than if the patient remains and is treated in the skilled nursing facility and utilizes F.C.R.A.'s services.

This report supports evidence that the continuing need of quality care offered by F.C.R.A. are essential and beneficial to the respiratory patient, the taxpayer and the state of Connecticut if medical costs are to be reduced.

PROPOSAL

The purpose of this Cooperative Study between the state of Connecticut and Fairfield County Respiratory Associates is to compile data to document the cost savings produced by independent respiratory services outside the general hospital or Acute Care Facility.

F.C.R.A. is an independent, privately owned, profit organization treating patients in the skilled nursing facilities (Level I & II) and in their homes. The treatments maybe IPPB, Ultrasonic, Postural Drainage, Induced Sputum, Nebulizer, Suctioning or a combination of these.

The goal of F.C.R.A. is to continue to provide respiratory patients throughout the state with quality care in a skilled nursing facility at a reduced cost. It was F.C.R.A.'s objective to ease the burden of high medical costs for the aged, taxpayer and the state of Connecticut by treating respiratory patients in the skilled nursing facility without the transfer to the general hospital.

The skilled nursing facilities have a contract with F.C.R.A. to treat patients. F.C.R.A. is an outside organization, with qualified respiratory therapists that treat patients on a 24 hour on call service including regular schedule treatments. All patients have to have a written doctor's orders documented before treatment is received.

The state of Connecticut has not yet approved Medicaid reimbursement payments for F.C.R.A. treatments. At the present time, the state does pay F.C.R.A. for treatments and equipment but this is only a Pilot Program (Experimental) This program has been in existence since August 1977.

Problems with Program:

The main problem with the program has been slow expansion. This stems from slow payments made by the state of Connecticut which has inhibited employment of more qualified people to service additional homes.

OBJECTIVE:

- (1) To compile statistics for the Medicaid study. In the study, I will show that it cost less to treat patients in SNF than transferring them to an acute care facility. (For respiratory treatments only)

The problem is that the state does not think they will save money if the patient remains in the skilled nursing facility, and is treated there.

METHOD FOR STUDY:

- (a) Show F.C.R.A. patient population
- (b) Show F.C.R.A. patient population increase over the years (1977 - 1981)
- (c) Compare prices; F.C.R.A. vs acute care hospital (treatment and equipment)

OBJECTIVE:

- (2) Set up a master patient index system
 - (a) patient index
 - (b) SNF index
 - (c) payment index
 - (d) treatment index

OBJECTIVE:

- (3) Develop a quality assurance program for respiratory care

OBJECTIVE:

- (4) Develop a permanent medical record

OBJECTIVE:

- (5) Set up statistical system
 - (a) number of patients treated/month
 - (b) number of new patients - quarterly
 - (c) treatment statistics

OBJECTIVE:

- (6) Develop permanent program which Medicare and Medicaid will

utilize in other areas of the country, assuring quality care by NBRT qualified therapists/technicians at minimum cost.

It was also calculated that approximately 3% of all patients admitted to a hospital (not with Fairfield County) were transferred from a skilled nursing facility to an acute care hospital for the purpose of receiving respiratory treatments.

There is a definite need for this service (respiratory) in skilled nursing facilities throughout the state of Connecticut.

F.C.R.A. patient populations

1977 (August)	31 patients
	21 Medicaid
	3 Medicare
	6 private
	1 denied Medicaid
1978	89 patients
	58 Medicaid
	17 Medicare
	14 private
1979	77 patients
	55 Medicaid
	15 Medicare
	7 private
1980	172 patients
	102 Medicaid
	49 Medicare
	21 private
1981 (August)	136 patients
	67 Medicaid
	52 Medicare
	17 private

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APPLICANT: Fairfield County Respiratory Associates, Inc.
4270 Main Street
Bridgeport, Conn. 06606

CONTACT: John M. Zavatsky, Jr.
President

TELEPHONE: (203) 371-0139

RESPIRATORY THERAPY SERVICES

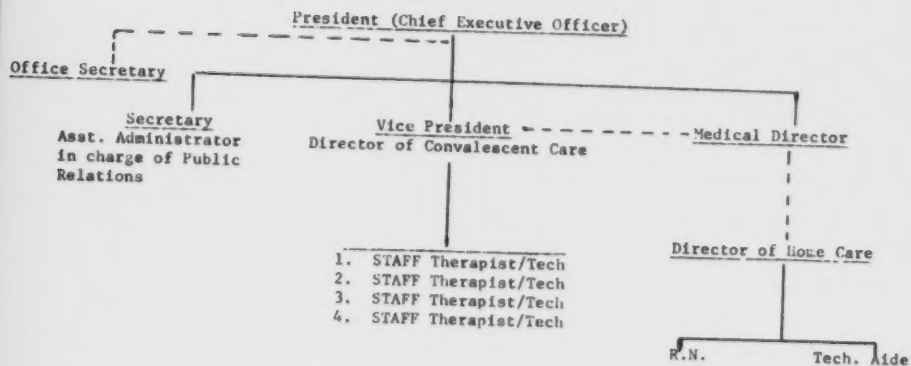
PROJECT: Review of Pilot Program for years '77 to '81

TITLE: Respiratory Services in skilled nursing facilities

STARTING DATE: August 22, 1977

COMPLETION: August 22, 1981

DESCRIPTION OF OBJECTIVES: It was Fairfield County Respiratory Associates' objective to ease the burden of high medical costs for the aged, taxpayer and the state of Connecticut by treating the respiratory patients in the skilled nursing facility without the transfer to the general hospital.

ORGANIZATIONAL CHART

Fairfield County Homes Involved in Study:

<u>City</u>	<u>No. of Beds</u>
<u>Bridgeport</u>	
Dinan Memorial Center	300
Park Avenue Restorative Health Care Center	132
Sylvan Manor	40
Golden Heights Manor	140
Roncalli Health Care Center	180
<u>Fairfield</u>	
Southport Manor Convalescent Center (discontinued)	120
Van Doren Convalescent Hospital	112
The Jewish Home for the Elderly	220
<u>Stratford</u>	
Lord Chamberlain	240
<u>Shelton</u>	
United Methodist Convalescent Home	140
Long Hill Convalescent	120
New Haven County Homes involved in Study:	
<u>Milford</u>	
Milford Heights	120
Golden Hill	120

Treatment Charges:

These charges have been reviewed and accepted by the state of Connecticut. These charges remain the same as they were at the onset of this study:
(August 1977)

Intermittent Positive Pressure Breathing	\$12.50
Ultrasonic Therapy	12.50
Induce Sputum	12.50
Nebulizer Treatments	10.00
Postural Drainage Therapy	8.00

The above charges are for therapy only and must be added to the facilities per diem rate to arrive at the total cost. This cost can be compared to that of the general hospital to derive the dollar benefit.

Respiratory services offered by F.C.R.A. are carefully monitored. Patients are reviewed daily by the Quality Assurance Administrator and weekly by the consulting physician. This system allows for the discontinuing of all unnecessary therapy.

Treatment Charges

<u>Fairfield County Respiratory</u>		vs.	<u>General Hospital</u>
<u>Treatment</u>	<u>Medicaid</u>	<u>non-Medicaid</u>	
IPPE	\$12.50	\$12.50	\$12.58
setup	N/C	N/C	12.58
Initial treatment	\$12.50	\$12.50	<u>\$25.16</u>
Ultrasonic	\$12.50	\$12.50	\$13.84
setup	N/C	N/C	<u>13.84</u>
Initial treatment	\$12.50	\$12.50	<u>\$27.68</u>
Induce Sputum c equip	\$12.50	\$12.50	\$12.50
Induce Sputum c equip	N/C	N/C	\$ 6.00
Nebulizer	\$ 8.00	\$10.00	\$11.50
setup	N/C	N/C	<u>6.50</u>
Initial treatment	\$8.00	\$10.00	<u>\$18.00</u>
Postural Drainage	\$8.00	\$8.00	\$10.98
Suctioning	-0-	\$8.00	\$ 5.00

*(Medicaid does not pay for suctioning)

It is quite evident that it costs less to the state if the patient is treated by F.C.R.A. than receiving treatment in a hospital. A cost analysis was done and determined that the cost of performing these respiratory treatments and of operating in the skilled nursing facility was considerably less in relationship to the hospital.

(Treatments, transfer fee, room and board were included in the overall cost analysis.)

Realizing the progress of modern medicine there exists a need for continuing respiratory rehabilitation for many patients. With respect to these advancements, the following rehabilitative and supportive therapies for restorative and chronic health care facilities are used.

It is our primary responsibility to administer proper therapy and respiratory care to patients, in accordance with physician's orders and accepted technical standards.

These services include:

1. Intermittent Positive Pressure Breathing (IPPB)
 - a. prevention of atelectasis
 - b. clearance of secretions
 - c. delivery of medications
 - d. achievement of improved gases
 - e. maintenance of patients and irreversible respiratory diseases
2. Aerosol Therapy and Ultrasonic Therapy
 - a. delivery of medication
 - b. decrease mucosal edema
 - c. liquify bronchial secretions
 - d. improve ventilatory function by bronchial clearance
3. Sputum Induction
Respiratory infection relapse in chronic and rehabilitative care facilities of patients with chronic lung disease is frequently due to penicillin resistant staphylococcus and therefore, culture and sensitivity of specimens is important.
4. Suctioning Procedure
The removal of airway secretions when effective cough is not present.
5. Percussion and Postural Drainage
Once obstructing secretions are mobilized through aerosol and positive pressure breathing procedures, care must be taken to ensure their evacuation. The physical procedures of chest percussion and postural drainage in conjunction with deep breathing play an important role.
6. Oxygen Therapy (where applicable)

Our objective concerning the preceeding therapeutic procedures are:

- a. to educate the patient to better enable him to cope with his disability.
- b. to improve the muscular pattern of breathing and to provide tools for the control of distressful symptoms.
- c. to provide and maintain adequate bronchial hygiene.
- d. to teach effective cough
- e. to improve ambulatory endurance
- f. to improve general tolerance to activity
- g. to improve general strength, range of motion, and posture as they relate to respiratory function.
- h. to teach the patient to coordinate his improved breathing pattern with movement in his activities of daily living.
- i. to wean chronic patients to a reasonable level of treatment frequency.

These above services are rendered on a twenty-four hour basis by skilled therapists/technicians under the direction of area physicians.

Since the costs (as shown on page 4) are what the average hospital charges, it is easy to see that these treatments being offered outside the general hospital, are proving an overall reduction in the total cost of providing this care. By treating the patient in the convalescent home you eliminate the high per diem rate at the hospital, in favor of the much lower convalescent rate. By treating the patient on an outpatient basis or in their own home, you totally eliminate many costs above and beyond the actual cost of the therapy. The validity in the above statements and figures is presuming that the only ailment the patient has is a respiratory disorder at the time and from past experience and review, this is most often the case.

In an effort to substantiate any theory of reduced cost by offering respiratory therapy outside the general hospital, I have produced a cost analysis evaluating (4) four (70) seventy year old men. Each man is suffering from pneumonia and all four were treated with TID nebulizer therapy for 7 days.

Patients A & B have Medicaid

Patients C & D have Medicare

<u>Year</u>	<u>Patient</u>	<u>Facility</u>	<u>Treated by</u>	<u>cost</u>
1977	A	SNF	FCRA	364
	B	AC		945
	C	SNF	FCRA	370
	D	AC	in hospital	980
1978	A	SNF	FCRA	392
	B	AC		1120
	C	SNF	FCRA	502.53
	D	AC	in hospital	1036
1979	A	SNF	FCRA	455
	B	AC	in hospital	1309
	C	SNF	FCRA	507.50
	D	AC	in hospital	1106.56
1980	A	SNF	FCRA	539
	B	AC	in hospital	1715
	C	SNF	FCRA	575.69
	D	AC	in hospital	1148

As you can see from these figures, the total cost of treating a patient in the convalescent home is much less than doing the same in a hospital (acute care facility). Regardless of which hospital you choose, or the form of respiratory care involved, it makes good sense to treat the patient in the nursing home. By allowing respiratory therapy to be covered under Medicaid and Medicare, there would be a reduction in the total cost, rather than the increase that many fear. In this age of fiscal restraint, it is a sound economic move to make.

In addition to the above information, I have taken 3 specific patients from our files and explained the waste of funds that could occur without F.C.R.A.

Example 1

In May of 1981 a 69 year old man was admitted to a skilled nursing facility under contract to F.C.R.A. This man was a direct admission from an acute care facility.

Diagnosis:

Bilateral subdural hematoma - coma due to hypoxia resulting from respiratory arrest.

Patient had a permanent Tracheostomy - was not ambulatory - had tube feeding and was prone to Aspiration Pneumonia.

He was unlucky enough to need respiratory care and be on Medicare.

	<u>Length of stay</u>	<u>Therapy involved</u>	<u>Total cost</u>
skilled nursing facility under care of F.C.R.A.	11 days	IPPB BID with trache- ostomy care and deep suctioning	\$1239
acute care facility	11 days	same as above	\$2695

Example II

In the fall of 1980 a 40 year old man was admitted to a SNF from the acute care facility.

Diagnosis:

Coma due to hypoxia resulting from respiratory and cardiac arrest

Permanent Tracheostomy

Prognosis: POOR

F.C.R.A. was not called in on the case; but patient was ordered on 21% aerosol to trach and QID ultrasonic treatments because the patient was suffering from an Acute Aspiration Pneumonia. The SNF called a rental company and ordered the aerosol and ultrasonic machines for the nurses to complete the therapy for 30 days.

Here is the result:

Compressed Air Tanks with aerosol - \$750 rental

Ultrasonic	- \$ 60 rental
	\$810 + medications and room rate

In December F.C.R.A. was called to evaluate the patient because the patient's wife could not afford this bill every month.

F.C.R.A. result:

(2) two compressors were sold to the patient	- \$119.00
	<u>\$119.00</u>
	\$238.00

The nurses not being accustomed to respiratory equipment and different treatment modalities were misled by the rental company. If Respiratory Therapy Personnel were called, the high cost could have been avoided.

Example III

F.C.R.A. has taken 4 patients home from the hospital that were in Intensive Care on continuous Mechanical Ventilation. These patients were totally in our charge, under physicians prescription. They were suffering from various diseases including: Amyotrophic Lateral Sclerosis, Acute Respiratory Failure and Chronic Emphysema. These 4 patients were unable to stay off oxygen or the respirator for longer than 15 minutes. It was F.C.R.A.'s purpose to maintain and wean patient in his own home.

The following is a cost analysis of the actual charges in the hospital vs. at home for 106 days.

	<u>General hospital</u>		<u>home</u>
room rate	\$24,308.98	nurses	\$6,056.00
respiratory therapy	\$25,213.16	respiratory (including O ₂ , equip, lab)	\$2,776.75
X-Ray	\$ 1,060.00	respirator	\$1,268.14
Laboratory	\$ 1,765.96	laboratory	103.00
Medications	<u>\$ 1,765.96</u>	medications	<u>90.00</u>
	\$54,114.06		\$12,293.89

SAVINGS:

\$41,820.17

Yet, this is the cost our Government still refuses to pay for Respiratory Services outside the general hospital under both Medicare and Medicaid.

Cost is not the only concern involved with this program. Patients treated in their own home (nursing or private) are more relaxed and familiar with their surroundings. This allows for better therapy and overall recovery. This familiar atmosphere allows the patient to feel more "normal." This way they feel less dependent on others and many times increases their desires to live, as is the case of many chronically debilitated patients; they lose all desire to continue to fight on. However, if you allow them to live as close to their original life-style as possible, they tend to recover faster and respond more favorably to care.

In the typical home care situation, either private or convalescent home, the patient is visited at least once a day. The treatments are ordered by the patient's physician and then delivered by a respiratory therapist/technician. The most modern and best applicable type of equipment is used. As the need arises treatments are increased or decreased by the attending physician, but in the case of the chronic patient, the prophylactic use of one or two treatments a day is normally sufficient. The use of such treatments prevents the patient from coming down with acute exacerbation of their disease.

Transfer to the hospital usually occurs when the patient has an acute onset of their respiratory disorder. This leads to further complications of other ailments including the heart or kidneys. If their respiratory disorder can be held at status quo, then the likelihood of further complications can be avoided. This eliminates the need for transfer to the hospital and results in a decreased cost.

The following statistics are from August 1977 to August 1981 representing 4 full years and emphasizing the cost savings produced by Fairfield County Respiratory Associates. The cost of therapy and the SNF cost in comparison to possible cost in the general hospital (ACF) will justify this program.

Obviously, all patients did not receive the same therapy nor was their length of therapy the same, but their attending physicians would have ordered the same therapy in the general hospital as they did in the SNF.

The formula for the following data was arrived from charges billed to the state by F.C.R.A. plus multiplying the patient days times the actual Medicaid (SNF) Skilled Nursing Facilities and (ACF) Acute Care Facility per diem rates. The same formula was used to arrive at Medicare costs and F.C.R.A. costs were charged directly to the patient. (All rates were acquired from area SNF's and area hospitals.)

		<u>FCRA & SNF</u>	<u>Cost to Medicaid Medicare</u>	<u>Cost in ACF</u>	<u>Total Savings</u>
1977 Aug 22-Dec 31					
patient } 542	\$14,492 + 15,176	= \$29,668	\$73,170	\$43,502	
days } 138	4,731 + 4,965	= 9,696.24	12,420	2,723.76	
1978					
patient } 2579	74,264.50 + 82,528	= \$156,792.50	412,640	255,847.50	
days } 215	4,912 + 8,984.85	= 13,896.85	20,425	6,528.15	
1979					
patient } 2189	81,739.50 + 76,615	= \$158,354.50	409,343	250,988.50	
days } 292	5,893 + 12,410	= 18,303	34,479.36	16,176.36	
1980					
patient } 2686	73,832.50 + 126,242	= \$200,074.50	658,070	457,995.50	
days } 751	16,207.50 + 39,254.77	= 55,462.27	135,180	79,717.73	
1981 Jan-July 31	42,453 + 93,810	= \$136,263	389,550	253,287	
patient } 1590					
days } 757	20,363.35 + 45,079.35	= 65,442.70	150,400	85,957.30	

TOTAL SAVINGS TO STATE OF CONNECTICUT,
THE FEDERAL GOVERNMENT AND THE TAXPAYER
DURING F.C.R.A. 4 YEAR STUDY =

\$1,452,723.70

In summary, I would like to quote Dr. Butler, Director of the National Institute of Aging, he said, "The genuine tragedy of old age in America is that we have fashioned a society that is extremely harsh to live in when one is old. The tragedy of old age is not the fact that each of us must grow old and die, but that the process of doing so has been made unnecessarily, and at times, excruciatingly painful, humiliating, debilitating, and isolating due to insensitivity, ignorance and poverty." These may seem to be harsh and cruel words, but they are true.

Continuing, Dr. Butler added, "The average age of the nursing home patient is 82 ... On average, they have four chronic or crippling disabilities. One-third of the population going into nursing homes recover, are transferred or die within the first year. Two-thirds remain more than one year and many remain more than five years. It is an elderly population."

These few words suggest what we have to begin introducing into our regulations, into our structure of dealing as regulators if we are to insure that patients receiving care in a long term care facility and private home receive quality care in a safe environment. We must move away from the notion that the paper, the credentials, and the ratios are all that is important.

It is our contention that we can lessen the tragedy of old age with these respiratory services, lessening the pain, humiliation and debilitation therein, allowing these patients to remain within the familiar environment they have grown accustomed to, while being treated.

This in and of itself is of utmost importance, however, as can be seen from the inclusion of cost, these would be a tremendous saving to the state and Federal Government and ultimately, the taxpayer by being able to deliver the respiratory services in the nursing home and private home.

The services we have to offer are needed, in order to provide them, funds are needed. Benefits will be severalfold, that is, to the aged who receive the care and to the taxpayer. Therefore, it is my hope that the State of Connecticut expands the Fairfield County Respiratory Program by validating our services in other areas of the state thus setting the stage for the entire country. This can only be accomplished if cooperation is given from the state, with regard to funding.

CONCLUSION:

It is quintessential to the State of Connecticut, (Medicaid), the taxpayer and most of all the patient, that F.C.R.A. continue to provide care in skilled nursing facilities throughout Connecticut. Quality care is given and still reduces the cost of treating respiratory patients.

There is a need for respiratory services in skilled nursing facilities. A Quality Assurance Program is submitted in this report to insure and monitor the quality care provided by F.C.R.A. Physician's endorsement letters are also included along with the high standards of the policy and procedure manual developed by F.C.R.A.

Overall, this health care agency is extremely beneficial in regarding patient care and keeping cost down, especially now, when health costs are rising and the government keeps cutting back on the health care budget.

QUALITY ASSURANCE ACTIVITIES FOR RESPIRATORY CARE

PURPOSE: Respiratory care agencies shall demonstrate a consistent endeavor to deliver patient care that is optimal within available resources and consistent with achievable goals. The respiratory care agency shall be well organized, properly directed, and appropriately intergrated with other units and departments of the Skilled Nursing Facilities. Staffing shall be commensurate with the respiratory needs of the patient and the scope of services offered.

OBJECTIVES:

- A. To identify important or potential problems or related concerns in the respiratory care of the patient.
- B. To objectively assess the cause and scope of problems or concerns, including determination of priorities for investigating and resolving problems.
- C. To be implemented by the Quality Assurance Administrator decisions or actions that are designed to eliminate in sofaras possible, identified problems.
- D. To monitor respiratory activities Designed to assure that the desired result has been achieved and sustained.
- E. To document reasonable substantiates of the effectiveness of the overall program to enhance patient care and to assure sound clinical performance.

The three main components of the Quality Assurance Plan are:

- (1) Effective Patient Care - the maintenance, partial rehabilitation or cure of the patient's respiratory condition.
- (2) Efficient Resource Use - creating cost containment programs that increase efficiency with little adverse impact on patients.
- (3) Return on Investment - profitability, the essence of organizational survival, is inexorably linked to efficient performance and quality care.

AUTHORITY:

The Quality Assurance Plan for Fairfield County Respiratory Associates Inc., in compliance with the Joint Commission on Accreditation for Hospitals (Respiratory Care Services) and the Professional Review Organization, is approved by the Administrator of Fairfield County Respiratory Associates (FCRA) and the executive board. Responsibility for the administration of the plan resides with the Quality Assurance Administrator. The responsibilities of this position include planning and coordinating the quality assurance activities. The person who holds this position reports directly to the Administrator of FCRA.

The respiratory therapists (STAFF) are a single organized staff that has overall responsibilities for the quality of all respiratory care services provided to the patients, and for the ethical conduct and professional practices of its members as well as accountable to FCRA.

IDENTIFYING PROBLEMS:

- A. The problem-focus approach to quality assessment activities required by JCAH includes the establishment of priorities and the use of clinically valid criteria.
- B. Internal data sources are to be reviewed by the Quality Assurance Administrator. These internal data sources include: Skilled Nursing Facilities, Medical Records, Infection Control Reports, Committee and Departmental Reports, Utilization Review and Audits.
- C. The Quality Assurance Administrator also looks at external data sources which includes: PRSO reports, PAS or similar indexing reports, Rate Setting and Commission reports.
- D. Each clinical discipline is responsible for identifying and resolving problems concerning respiratory care, administering and coordinating the overall Quality Assurance Program to be performed by the Quality Assurance Administrator.

SCOPE OF THE QUALITY ASSURANCE PLAN:

In coordination/integration of FCRA's quality assessment and control activities related functions should be considered: Emergency Service; Functional Safety and Sanitation; Governing Body; Home Care Service; Infection Control; Medical Records Services; Nursing Services; Rehabilitation Programs Services; Social Work Services; Medical Staff; and Utilization Review.

PRIORITY SETTING:

Once an actual or potential problem is identified, it may be assessed prospectively, concurrently, or retrospectively. Whatever time frame for the review and whatever quality assessment activities are used, representative care (that is adequate sampling) provided by all Skilled Nursing Facilities and individual respiratory therapists. Priorities will be assessed by the Quality Assurance Administrator. Considerations for prioritizing problems are:

- severity of patient impact
- number of patients affected
- cost involved, available resources
- staff motivation, effort required
- duration of problem

IMPLEMENTATION:

- A. Appropriate action must be implemented to eliminate or reduce the identified problem by the Quality Assurance Administrator.
- B. Appropriate action may include:
 - Education/Training programs
 - New/Revised policies and procedures
 - Staffing changes
 - Equipment/Facility changes
 - Change privileges/procedures
 - Monitoring/Action results
- C. Periodic monitoring of the result of the corrective action taken must be conducted to assure that the identified problem has been eliminated or satisfactorily reduced.

- D. The Quality Assurance Administrator in compliance with the Administrator of FCRA has the authority to make changes that seem fit.

MONITORING:

The institution of appropriate action and monitoring results of such action to assure resolution of identified problems are critical elements of an effective Quality Assurance Program. Respiratory Agency monitoring action must be taken to assure sustained resolution of problems has been achieved.

The extent to which monitoring activities are necessary depends on the degree of success achieved when the corrective action is first monitored. In many instances appropriate corrective action will require only initial monitoring. If, on the other hand, initial monitoring indicates that the type of corrective action was appropriate by the Quality Assurance Administrator, but performed inadequately, routine monitoring by the Quality Assurance Administrator over a period of time might be necessary. More extensive monitoring may frequently be necessary to assure that resolution of the problem has been sustained.

EVALUATION:

The Quality Assurance Administrator is responsible to document the annual reassessment which may consist of a list or summary of relevant findings, actions required to either assure or improve the coordination and integration of quality assessment activities within the program, and evidence of program's impact and improving respiratory clinical performance and patient care.



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November 13, 1981

Senator Orrin Hatch, Chairman
Labor and Human Resources Committee
4230 Dirksen Office Building
Washington, D.C. 20510

Dear Senator Hatch:

Our Washington representative, Fran Butler, spoke with your staff recently about our concerns regarding including specific language about Senior Companions in your bill S 234 and about submitting materials for inclusion in the record of your hearing on November 10 of the U.S. Senate Labor and Human Resources Committee.

Enclosed please find my opening statement and two attachments. I would hope you would include the statement and attachments in the hearing record. I have also reviewed the "cordon print" that was given to Fran Butler and would make the following specific suggestions about including language related to the Senior Companion Program. On the 7th page under "Discussion relative to home health services," I would suggest inserting this additional language: "(5) to the extent permitted in regulations the services of a Senior Companion are considered home health services which include personal care services, household care services, transportation services, and other services as appropriate and are considered to be carried out under the appropriate professional supervision when provided by a trained Senior Companion. Training of Senior Companions and other volunteers over 60 years of age should be given priority in the implementation of this measure. The Secretary and the Director of AOA are authorized to cooperate with the Director of the ACTION agency and the Older Americans Act Volunteer Program Director in the implementation of this section."

I offer an additional suggestion on your page 8 under the "Social Security Act changes." Your cordon print states, "notwithstanding any other provisions of this title, the term home health services includes 'without regard to any of the preceding provisions of this subsection' any health services provided in an individual's home by a home health agency or non-profit hospital"--here I would suggest you add, "or Senior Companion Program"--then your language continues, "which agency or hospital"--and here I would add, "or Senior Companion Program"; your language continues, "has an agreement with the Secretary under Section 1866." Then your language continues, "or by members of its staff acting as such (including physicians, nurses, social workers, therapists, technicians, home health aids, respiratory therapists, homemakers, housekeepers, pharmacists, dieticians"--and here I would request inserting: "Senior Companions"--and your language continues, "and other personnel."

Senator Orrin Hatch
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The 1600 members of our Foundation are most supportive of both the home health training aspects and the income tax credit aspects of your measure. We are particularly concerned that special attention is given to the training of the elderly to help one another rather than concentrating most of the training on younger people.

We appreciate the opportunity to present these ideas to you. When I am in Washington to attend the White House Conference on Aging, I hope that I will be able to meet with you and/or your aide Judy Stefanki. Thank you for your concern for older Americans.

Sincerely,

A handwritten signature in dark ink, appearing to read 'Steven W. Brummel', followed by a long, sweeping horizontal line that ends in a small upward curve.

STEVEN W. BRUMMEL
Executive Director

SWB:sc

Enclosures

cc: Congressman Leon Panetta
Fran Butler



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STATEMENT BY STEVEN W. BRUMMEL,

Executive Director of the ELVIRITA LEWIS FOUNDATION

Senator Hatch and members of the U.S. Senate Labor and Human Resources Committee:

I am pleased to present the views of our 1600 members of the Elvirita Lewis Foundation for your consideration. The Elvirita Lewis Foundation, a small national non-profit charity created by my grandmother to help the elderly help themselves, would like to strongly endorse Helen Hayes statement that all too often great age reduces American older people to the legal and emotional status of a child. Often this is because well meaning professionals, while providing needed services to the elderly, demean them by not valuing the resourcefulness and decision-making capacity of the elderly themselves. We strongly support home health services rather than institutional services for older people and in that regard, request that this statement and the two attached papers, entitled "The Senior Companion Program, Older People Providing the Solution to the Problems of Older People" and "Who Needs a Doctor to Check Hanna's Refrigerator?" be included as our testimony in the record of the November 10 hearing of the U.S. Senate Labor and Human Resources Committee. We support Senator Hatch's S 234 and encourage the Senator to include specific language regarding the Senior Companion Program in this legislation emphasizing the need to train senior citizens to provide these needed personal care and household care services to their frail elderly peers.

Thank you for allowing me to present these materials. I look forward to receiving a copy of the hearing record.



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THE SENIOR COMPANION PROGRAM

Older People Providing the Solution to the Problems of Older People*

A population with more older people and a longer life span is a reality that all communities must come to terms with in the next 25 years. There will be large numbers of healthy people over 60 who, because of good nutrition and advances in medical care, want to continue to work and to be a part of the ongoing life of their communities. We will also have a growing number of the frail elderly, people who need assistance with the tasks of daily living for some period during their later years. It makes sense in every way--economically, as well as in human terms--to use the energies, experience and age-empathetic skills of the healthy elderly to provide care, friendship and services to the frail elderly.

A format for such a program has been in place for four years. Called the Elvirita Lewis Foundation--Elder Independence Senior Companion Program, it has brought Companion services to more than 1200 older people in the Monterey Bay Area, keeping several hundred from premature institutionalization. It is the purpose of this paper to present the assumptions on which the program is based, its advantages, its relationship to the ACTION model, and possibilities for its future development under the current administration.

*presented to the San Mateo County Commission on Aging, Nov. 9, 1981; to the U.S. Senate Labor & Human Resources Committee Hearing, Nov. 10, 1981; to the California Senate Subcommittee Hearing on long term care, Nov. 13, 1981; to the Santa Cruz County Board of Realtors, Nov. 23, 1981; and to the White House Conference on Aging, Nov. 30 to Dec. 4, 1981 by Steven W. Brummel, Executive Director of the Elvirita Lewis Foundation.

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1. What it is. Senior Companions are older volunteers trained to provide or obtain whatever assistance is necessary to keep the frail elderly in their own homes for as long as possible, and to add to the quality of their lives in a variety of ways. While sharing the activities of friendship and visiting with traditional Friendly Visitor Programs, Companion Programs operate on quite different assumptions. Companions are given the responsibility for keeping their clients at home if medically feasible, and they are given the training that will develop their skills in assessment and in the use of available community resources. They learn supportive behavior and how to tap whatever capacities their clients have to help themselves and to help those even more frail or impaired. Companions assess each client's needs and request from community agencies assistance such as chore services, legal services and prepared meals as appropriate. Companions themselves provide socialization and the support of a helpful friend. They provide transportation for medical care and shopping and also follow up to be sure services as outlined and agreed to are provided. Perhaps the most important part of their efforts is the networking of clients with each other and with people of all ages in their communities that care about older people.
2. The Assumptions. The program is based on the following assumptions:
 - ...that older people accept assistance more readily from their own colleagues and from their own age-peers than they would from social service or medical professionals;
 - ...that the networking of older people with other older people develops a sense of community and retards passivity and isolation, weaving or

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maintaining the fabric that gives an older person a richer quality of life;

- ...that the frail elderly would rather tolerate substantial physical discomfort living at home while having someone who cares look in on them, than enter nursing homes--a move which tends to occur more from a sense of isolation than from a real need for the expensive and not always appropriate services offered;
- ...that for Companions, the sense of competence and effectiveness developed by knowing about community resources and being given the responsibility to use that knowledge will enhance their own health and feeling of control over the their own aging process.

3. The Benefits. Senior Companion Programs provide the following benefits:

- ...the frail elderly served--a population of increasing impairment--can be maintained in the comfort and dignity of their own homes;
- ...the Companions become community resources, functioning in new ways, solving community problems and remaining self-supporting. Many of these low income elders undergo transformations in confidence, competence, and appearance as they receive the respect and interest of new segments of the community;
- ...the community can provide services in the areas of the greatest need, and agencies can become responsive to ethnic groups and isolated people who are unaware of the benefits offered by the social service system. The truly needy are served--not just those who know how to "work the system". Asian Companions can appropriately help Asian elders; Hispanics know intuitively how to assist other Hispanics.

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...Institutionalization of frail elders may be deferred, shortened or eliminated at a substantial savings of tax dollars.

...A positive cost/benefit ratio can result from the reduction of public funds spent on inappropriate social services for the elderly. Expensive professionals are used only for training and for emergency or highly defined services rather than for activities that a Companion can do as well or better.

4. The ACTION Model. The Domestic Volunteer Services Act of 1973 provided federal ACTION funds for a small number of Companions (today only some 5,000 nationwide) in an institutionally-based volunteer format. The compensation provided is referred to as a stipend, and is presently \$2.00 per hour. The volunteer also receives a meal allowance of \$2.00 a day and a travel allowance of \$1.95 a day. For 20 hours a week, the compensation for one year totals just over \$3,000. The stipend is non-taxable, and does not interfere with any benefits an older person might be receiving such as private pensions, Social Security, or SSI.

We at the Elvirite Lewis Foundation support the stipended volunteer concept as a way to bring services to the frail elderly while providing a small amount of extra income to the healthy elderly. The ACTION Senior Companion Program has provided an initial model but could be even more effective if it discontinued the Volunteer Station and other professional requirements. ACTION requires supervision and assignment to be provided by area institutional service providers. This practice assumes that professionals are required, makes for continual reinvention of the wheel as each agency develops rules, and orients the

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program toward providing services to residents of institutions rather than to older people in their homes. The whole preventative aspect is diluted and the use of the common sense skills of older people is lost; the Companions become dependent on official directions, rather than self-sufficient and responsible. This institutional bias developed when Senior Companion rules were adapted from those used by Foster Grandparents, a program in which school (institutional) supervision was appropriate and realistic. For a home-based model, however, the following structure has proven efficient and effective: a Program Director handles general leadership of the program, making initial assessments of client needs and assigning an appropriate and compatible Companion, and provides the Companions with 40 hours of training; elder Lead Companions provide extra resources in specific geographic areas, and elder Companions do the day-to-day work. Professionals are called in to provide specific ongoing training twice a month for all the Companions. In this way, procedures and terminology are standardized rather than fragmented, and the training sessions themselves provide a basis for socialization, peer support and improved networking among all the Companions. Program-wide meetings also offer the Director an opportunity to interact regularly with the volunteers and maintain control over how the program is run.

5. The Possibilities for Future Development. Congressman Leon Panetta has introduced HR 1890, the Older Americans Alternative Care Act of 1981. One provision of his bill expands the Senior Companion Program according to the Elvirita Lewis Foundation home-based model. In introducing his bill, Congressman Panetta stated (Congressional Record 2/18/81):

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"The Senior Companion Program is a model of cost effectiveness, which serves not only the frail elder, but also utilizes low-income healthy elders as the deliverers of client services...Rather than creating another expensive program based on expensive professional intervention, I believe it makes a great deal of sense to expand the program...By providing companionship and support, help with the daily responsibilities such as food shopping, medical appointments, referral to other community services and professional help if necessary, the Companion provides vital assistance in maintaining independence."

The bill asks for \$100,000,000 to carry out its provisions on a national scale, supporting one older person as a Companion for 15 to 20 severely frail elders. More than 2.5 million elders are estimated to be moderately or generally impaired. These are the people who could most benefit from the assistance of the approximately 500,000 low income older people who are eligible and willing to become Senior Companions. Older people today fear convalescent hospitals and don't like handouts. Companions offer an alternative. In addition to the federal legislation, Assemblyman Stan Statham has introduced AB 1571 which provides \$2 million for Senior Companions throughout California. Coauthors are helping this measure through the state legislature. Your support of these bills is requested by many older people who want the chance to be as independent as possible in their later years. We urge county and city commissions and councils to endorse these measures and to develop Senior Companion Programs with local public and private funds. We urge business and professional associations and individuals to make donations available to Senior Companions and to recommend this legislation to their elected officials.

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We hope to see the expansion of the Senior Companion Program as the cornerstone of coordinated care for older people. It offers a return to the use of the community's natural caregivers. It proves the efficacy of the "ownership" model for the accomplishment of a task: if a person has the responsibility, he or she "owns" the results, and the level of functioning is demonstrably higher. Because it is a human service rather than a medical model, the Companion program accents support, integration and adequacy rather than deficiency and repair. It is preventative, service oriented and encourages independence in the home rather than treatment and institutionalization. It is also substantially less costly than the professional, bureaucratic, legal, and medical approaches now being used.

If our aim is to return to the notion of independence formerly characteristic of our communities and individuals, the Senior Companion Program offers a cost-effective way to do so. It supports the independence of the volunteers as well as that of the adults served; the medium conforms with the message.

We urge your support for Senior Companions.



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WHO NEEDS A DOCTOR TO CHECK HANNAH'S REFRIGERATOR?

Steven W. Brummel and Winifred Siegel

Since the end of World War II, many administrative bureaucracies have developed to provide services to the elderly. The symbiotic relationship these bureaucracies have with funding sources has resulted in the perhaps unintended effect of professionalizing service delivery, because grants developed by professionals have included mandated services by professionals. (Estes, 1979). The highly trained managers, researchers, physicians and social workers required by grants have created the mystique of expertise and applied it in a broad swath that will "cure" all social problems. In the process, we have lost sight of the abilities of older people themselves to solve many of their major problems: loneliness, isolation, despair, malnutrition, insufficient housing, drug abuse, and crime.

As stated in a report developed by the Senate Subcommittee on Human Service, (U.S. Congress, 1980):

"It will not be easy to overturn this myth that human services can be provided only by professionals. During the past twenty years, the professions have attempted to gain ascendancy in the field of social behavior by tightly organizing and institutionalizing themselves. As a result of this maneuver, people have become virtually passive clients. Classes of professionals have come to impute classes of needs to classes of people. In fact, the orientation of a service bureaucracy demands that a certain class of people be defined as being in need. Nowhere is this more clear than in the health field where biases about seniors abound."

Examples of professionalism and the way in which it distorts advocacy efforts are lawyers who advocate more legal programs for the elderly, doctors who advocate more medical services and assessments for the elderly, social service providers who advocate expanding the bureaucratic social service network. In all these cases, what results is higher costs for taxpayers to handle and jobs for more doctors, more lawyers, and more social workers.

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It is the purpose of this paper to confront the idea that professionals are essential to all levels of service provision and to explore an alternative: that older people are competent to solve their own problems. The myth of necessary retirement (i.e. no longer being productive) closely followed by senility is an inappropriate and inaccurate assessment of the value to society of older people (Butler, 1973). I would suggest that new models of service provision should consider older people not as recipients, but as providers of services. In seniors we have an untapped pool of resources; it is estimated that there will be 40,000,000 older people in the United States by the year 2000 . A radical approach to solving the problems of older people is to give "consumer power" and "worker power" decision-making directly to the older people themselves, rather than diluting that decision-making. Older people would exercise more options and have more opportunity for usefulness and independence. (Califano, 1978).

Professionals simply are not needed in the provision of many human services. Their expertise should be devoted to the most technical end of the continuum of needs, rather than being universally applied to every service, every interaction, even when common sense suggests otherwise.

Many innovative models exist for the provision of needed services. In San Mateo County, California, for example, the problem of assisting indigent defendants is handled not by a government-operated bureaucratic organization employing public defender attorneys, but rather by a private defender program which calls upon volunteers from the County Bar Association to defend those who cannot pay for their defense. This format, each Bar Association with a list of attorneys providing services to older people and paid according to the older person's ability to do so, provides high quality services and a reduction of costly administrative expenses.

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Severe medical needs should be handled by doctors and paid for by Medicare, but many of the remaining problems of older people can be addressed by seniors who want to remain active (SRI International, 1980). There is a mechanism already in place in which older people are providers rather than recipients of services. The programs have been operating for some years, though not at anywhere near potential. Guidelines have been written; a focal point for facilitating the format is in place in Washington, DC, and could easily be adapted to a wide variety of functions. This mechanism is the Older Americans Volunteer Programs, operated by the ACTION agency. Both stipended and unstipended volunteers provide assistance to young children, to the handicapped, and to other older people, through RSVP, Foster Grandparents and Senior Companions. If the OAV Programs were expanded to the level that every older person who chose to do so could have a position, a majority of retired Americans could be providers--useful rather than useless.

In the FGP program, older people work with children with special needs--the handicapped, blind, abused, neglected. They work with youthful offenders, and with parents who abuse children (and who often were abused themselves). They do so as the community's natural support givers, providing love and non-judgmental help. They give this help as Foster Grandparents and this structure reduces the stigmatization and permanent labelling the recipients would endure if they were placed in treatment settings. Foster Grandparents do, in fact, provide "mental health services" but the recipients aren't "clients" and they are not categorized in a negative way for participating in the relationship with the Grandparent.

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Senior Companions offer the possibility of providing home care services to other older people as an alternative to inappropriate hospitalization. The recipients benefit highly, since Companions, too, are the natural care-givers of the community and personal services are better received if offered by a person of similar age (Furchtgott & Rusemeyer, 1981).

Companions are highly effective in giving frail elders a sense that they have someone to depend on and the interaction allows them to remain at home. Companions can be given the task of figuring out what their friends need, and they can do so because of ethnic, class and age commonality. When trained in community resources, they can coordinate a wide variety of support services with minimal bureaucracy and maximum individualization of services. Do we really need a nurse or a doctor to tell us that the refrigerator is empty? That the roof needs repair? That a letter needs to be written? Companions can make these assessments, take care of the problems, and do so in a non-medicalized way. Companions are paid a small stipend and use this compensation to supplement their incomes. At the same time, they have the opportunity to continue to function at a high level as knowledgeable, responsible, and healthy members of the senior community.

A number of in-home health proposals are currently being developed as alternatives to institutionalization, but only Companions accent the use of the community's natural caregivers. Adult day health centers, while effective in many ways, provide care for the frail elderly and respite for family caretakers, but they do so in the most expensive, least humane and most demeaning format possible. Most California day health centers must conform to medical staffing and equipment standards that ensure medically, rather than socially oriented services. Emphasizing the interpersonal and

-MORE-

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social, Companion services respond to the knowledge that many physical symptoms are in reality signs of depression and inactivity. Companions link the frail elderly with each other; they phone each other, share meals with one another, read to each other, make doll clothes together for a child care program--using rather than ignoring whatever capacities the frail elder has.

Many services now performed by government agencies could be done as well by seniors themselves. How about nutrition? Substantial funding is given to hot meal programs at nutrition sites. Are seniors paid to provide these services? Or does the funding money go elsewhere? In many cases, older people would be better off if we gave them the money that the program costs and let them choose where they want to eat. Maybe they'd like to go to MacDonald's, maybe elsewhere. For what the program spends on administration, they could go to any medium-priced restaurant. Seniors go to a center to eat, because it's surely better to eat there than to look at the four walls at home. But how can we unquestioningly support a system in which people in the last years of their lives have no choice in what to eat, even though enormous sums of money are spent on these programs? Another option: could we not distribute, with the Social Security check, food stamps that could be spent in restaurants? Why not give options back to older people and reinforce age-integrated rather than age-segregated activities?

Legislatively, an interesting alternative is being offered by Congressman Leon Panetta's HR 1890, the Older Americans Alternative Care Act of 1981. The bill would provide a tax exemption to families who keep frail elderly parents at home and provide \$100 million for a substantial expansion of the Senior Companion Program nation-wide.

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Substantial expansion of funding for Foster Grandparents and RSVP should also be provided. RSVP Volunteers can operate many essential services, and as these programs in which older people help older people expand, other professionally provided services which prove redundant or unnecessary can be eliminated. The programs that remain can be administered by the elderly themselves, rather than by younger professionals augmented by advisory councils of senior citizens who have little real input into decision-making on how program dollars are spent.

More important, all programs we develop to bring services to seniors should be evaluated to see if we are providing options, decreasing dependency, and using the capabilities of the young-old to help the old-old. When the post World War II baby boom generation reaches the age of the young-old, we must have constructive roles available. Remaining useful, important and vital are important attitudes to be maintained, and they are not nourished when one receives the "hand-out" of a free meal at a senior center or provided a repetitive craft at a recreation program, or told to wait one's turn, or asked patronizing questions. The attitude that older people are useful should be reinforced by creating those mechanisms that support such assumptions. The private sector as well as the government can be asked to support these mechanisms, which espouse the same independence and individuality they espouse in their businesses. Government currently spends a billion dollars on services for the elderly, not including Social Security or Medicare. Most of that billion dollars goes to professional salaries. How about giving that billion dollars to the elderly?

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Is it really a radical approach to treat older people as we do other age groups? Can we not allow them diversity of activity, of choice, of service to their communities? Can they not be given the responsibility for caring for those with whom they can best empathize? I fear that if we do not address this problem, we will precipitate an aging crisis of vast economic and human proportion, and will condemn ourselves to a barren old age rather than "golden years" of useful and participating activity.

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HOME HEALTH AGENCY ASSEMBLY OF NEW JERSEY, INC.

760 Alexander Road CN-1 • Princeton, New Jersey 08540

Center for Health Affairs
(609) 452-9290

Responses of the Home Health Agency Assembly of New Jersey to S-234

The Home Health Agency Assembly of New Jersey is the State Association which represents the 47 certified home health agencies in the state. The Assembly would like to congratulate the Senator for proposing S-234 and seeking alternatives to institutional care by expanding Medicare and Medicaid provisions. Your bill, S-234, proposes assistance to elderly persons to maintain their independence and stay in their communities with their families. We feel this is a cost effective and humane approach and we appreciate the opportunity to comment on S-234. We would like to share some comments from our prospective.

MEDICARE AND MEDICAID PROVISIONS (Sec. 4)

The expansion of medicare and medicaid to include chronic nursing services, transportation and respiratory therapy for those with chronic obstructive pulmonary disease is a generous and sweeping change. We believe it is good to include these services, but it would be best if they were studied and analyzed for cost before there is national application. The Committee might consider trying this on a demonstration basis, either in a limited geographic area or with a time constraint, before instituting these changes on a national basis. The Committee might wish to review nutrition services as a significant benefit.

HOME HEALTH AIDES

We would like to comment on home health aide training. Our experience has indicated that sixty hours of classroom instruction rather than forty hours is necessary to provide safe and competent performance. The curriculum prepared by DHEW and tested in New Jersey in 1978, 1979 and 1980 provided the sixty hours of instruction and resulted in well trained aides. Equally as important as training is the supervision of the aide. The best person to provide this supervision is one who utilizes the holistic practice of nursing and has had public health nursing experience. The purpose of homemaker home health aide service is to promote functional independence of an individual. This includes personal

Page 2

care services such as bathing, exercising, grooming, transferring, toileting, insuring good nutrition, preparation of food and prevention of accidents by maintaining a safe living environment. In order to accomplish these goals, the activities prescribed must be performed with the overall view of the patient's complete function and co-ordinated by the nurse. If the plan of care calls for the home health aide to supplement the rehabilitation plan of the therapist by ambulation and exercise, then it would be safe for the therapist to supervise the aide in those functions only.

CERTIFICATION REQUIREMENTS

S-234 provides for a non-profit hospital to provide home health care without Medicare Home Health Agency certification. Current Medicare law recognizes the differences in the delivery of inpatient hospital care and home health care. The Home Health Agency certification requirements support and recognize this distinction in the way care is given. The conditions of participation for a home health agency establish standards and serve as a mechanism for evaluating whether those standards have been met by the agency. If conditions of participation for the home health agency are not required for the hospitals, there will not be standards to evaluate the performance of the hospitals in providing home care. We cannot support this gross inequity in certification and standards. We have no objection to hospital based home health agencies provided they are under the same requirements. We believe that hospitals and communities should see that home health care is made available where the services do not currently exist.

In oral testimony given on November 10th, it was stated that an appropriate target population for hospital home care would be the 5% of elderly persons who are the most frail and therefore in need of the most medical intervention in order to stay out of the institution. An option to serve this group of elderly would be the use of geriatric nurse practitioners who have expanded skills in observations and monitoring of elderly persons for signs of change in their condition.

REIMBURSEMENT MECHANISMS

S-234 calls for demonstration projects to test reimbursement mechanisms such as fee schedules, prospective reimbursement and capitation payments. We agree

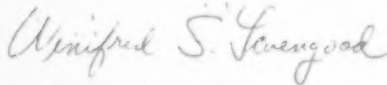
Page 3

that it is necessary to find the best, most cost-effective manner of payments and would look forward to the results of the demonstrations.

INCOME TAX CREDIT (Sec. 5)

This portion of the Bill which will give an income tax credit to those families who care for an elderly dependent will surely boost morale and help foster goals of keeping elderly persons with their family. We would recommend review of the definition of "qualified individual". The current definition seems fairly broad as so many elderly suffer from chronic impairments which are "long continued" and of indefinite duration.

We thank you for the opportunity to make these comments and will continue to be available to assist in this legislation.



Winifred S. Livengood
Executive Director
Home Health Agency Assembly of N.J., Inc.

November 19, 1981

Mr. Ronald Dockson
Senate Labor & Human Resources Cmte.
Sub-committee on Health
G 237 Dirksen Senate Office Bldg.
Washington D.C. 20510

Dear Mr. Dockson:

The American Association for Respiratory Therapy (AART) welcomes the opportunity to provide comments on the revised bill, S 234, Community Home Health Services Act of 1981. The AART wishes to commend the sponsor, Senator Orrin Hatch, on this important legislation which provides more comprehensive coverage of traditional home health care benefits.

Due to current reimbursement restrictions, most notably in the Medicare statutes certain home health care services are not covered as Medicare benefits. Traditional patterns of provider and consumer utilization of health services, whether appropriate or not, in reality dictate what services will be covered. As a result, extensive home health care tends to be unavailable because the services are non-reimbursable. This limitation costs the Medicare system millions of dollars annually. By acknowledging the cost effectiveness of home health care, S 234 attempts to rectify such inequities.

A further illustration of the great need for a revised and sensible reimbursement system for home health care was publicized by President Reagan during his November 10th press conference. Due to a severe respiratory ailment, three year old Katie Beckett has spent nearly her entire life in a hospital. Home health care services could effectively meet Katie's medical needs while allowing her to remain in her own home. The estimated cost for her home care would be a net savings of \$5,000 monthly. This much more desirable situation cannot occur because of inequities within the Social Security law, in this case the Medicaid system. Medicaid will not reimburse for this home care service and therefore the child remains within the hospital, a costly and socially undesirable setting. In an era of fiscal restraints, it seems unconscionable that a reimbursement situation such as this must occur. Senator Hatch has been a staunch supporter of the cost effectiveness of home health care services. S. 234 has been introduced to rectify the inequities in the reimbursement system.

The AART wishes to make the following comment on the revised S 234.

* The AART is especially pleased that the revised bill has incorporated



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legislative language that includes coverage of respiratory therapy home care for patients suffering from chronic obstructive pulmonary disease (COPD). Two well documented studies have provided evidence that in circumstances where respiratory home care is provided to elderly patients suffering from COPD, there is a substantial decrease in Medicare inpatient hospital days. The decrease in inpatient days in turn provides cost savings to the Medicare system. The AART supports the limited scope of the respiratory therapy home health care benefit. As an Association we have the responsibility to make our recommendations on well documented evidence, and an understanding that this important quality control element will assure significant cost savings and only appropriate utilization.

Overall, the proposed legislation is a well reasoned and carefully constructed document. It prudently institutes needed changes in the health care system without making those changes indiscriminately.

The American Association for Respiratory Therapy strongly supports this bill as currently drafted.

Sincerely,

George A. West, RRT
President

GAW/cb

Home Health Care for the Aged

Summary of Testimony Prepared for Hearings

November 10, 1981

on

S. 234

Community Home Health Services Act of 1981

Senator Orrin Hatch

Travenol Laboratories, Inc.

Parenteral Products Division

TRAVACARE® Services

Travenol Laboratories, Inc. is a major manufacturer of parenteral, blood therapy, renal, urological and medical care products. As a major supplier in the health care field, our corporate goal has been one of "Innovation for life." In keeping with this goal, Travenol Laboratories, Inc. has placed tremendous emphasis on the market for home health care products and techniques. This emphasis is evidenced by our Servipak® and TRAVACARE® groups who provide home medical products and services to patients requiring hemodialysis, chronic ambulatory peritoneal dialysis and total parenteral nutrition.

Total Parenteral Nutrition (TPN) involves the administration of solutions rich in calories and proteins via a silicone catheter threaded into the superior vena cava and tunnelled under the skin. This therapy is required for patients suffering from a gastrointestinal disability making the absorption of adequate nutrients impossible. Those affected include people with insufficient bowel length or short bowel syndrome, episodic inflammation of the bowel or Crohn's disease, abnormal connections between their bowel and other structures or fistulas and severely damaged bowels due to radiotherapy for cancer of various abdominal organs or radiation enteritis.

Significant technological advances have occurred in the past decade which make home TPN a viable alternative to continued hospitalization. The recent development of flexible three-liter containers has provided a closed system which reduces the possibility of solution contamination due to air borne contaminants. Improved administration sets with in-line air eliminating filters minimize the danger to the patient of both microbial contamination and air embolism due to accidental air entering with the I.V. fluids. More accurate pumps have been designed for intravenous infusion making it easier to monitor the volume of solution entering the patient over a period of time and warning the patient of problems occurring within the infusion system. New silicone catheters with Dacron® cuffs have been developed which minimize the hazards of infection and the possibility of the catheter becoming dislodged. The surgical techniques used in catheter placement and the subsequent care of the catheter have also shown improvement. In addition to the technical and device related improvements, a wide variety of nutrient solutions with common additives are now available pre-mixed for maximum safety when used in the home.

It is the intention of Travenol Laboratories, Inc. to provide health care of the highest quality at the lowest possible price. Our TRAVACARE® Services Home Supply Management Program makes such quality care possible by combining with hospital practitioners to provide Total Parenteral Nutrition in the home. The cost savings of such an approach are significant.

For example, a TPN patient recently hospitalized in a Michigan facility incurred charges at an average daily rate of \$377.00. This same patient is currently at home receiving the same TPN at a daily cost of \$150.00. This represents a savings of \$227.00 per day, on the average, or a 60.2% reduction in expenditures. If these expenses were annualized, the total cost for hospitalization would be \$136,605.00 per patient year while the total cost of TPN supplied to the patient at home would be \$54,750.00 per patient year. Thus, the annual savings that is experienced because the patient is at home is \$81,855.00 per patient year.

In addition to the actual savings experienced by taking the patient from the hospital to the home, there are definite psychological and social benefits. The chronically ill patient is placed in a more natural setting which enhances their outlook on life, their self concept and their relationship with their family. Many home TPN patients are able to resume a near normal life style, going to work or school daily. They are returned to society as productive, functioning human beings. Because of this fact, they are able to deal with their health problems in a much more hopeful manner.

The incentives for third-party reimbursement for Home TPN services are there. In 1977, Medicare agreed to cover the costs of supplies and pharmaceuticals for home TPN patients over the age of 65 or who were eligible for Medicare disability. This is an important step forward, however major disincentives persist within the reimbursement system making it difficult or impossible for many TPN patients to return to their homes. Four such disincentives exist: the question of waiver of disability, patient training and education, home nursing and Medicaid reimbursement policies.

The first and most important disincentive is the Medicare requirement that the patient, under the age of 65, be declared disabled in order to become eligible for benefits. Additionally, once the patient is declared disabled, he must wait two years for his TPN therapy to be covered. During this two year period, patients are often left with no coverage and are forced to liquidate their hard earned financial resources to qualify for Medicaid.

This situation creates not only a severe financial burden for the home patient, but also has major impact on the social and psychological adjustments the patient must face. On the one hand we are sending the patient home so that they might return to as near a normal life as possible and on the other hand we are preventing the patient from engaging in gainful employment. If consideration could be given to a waiver of disability for the person requiring Total Parenteral Nutrition, the person who is able to work would gain tremendously not only psychologically and emotionally, but also by knowing that they are contributing something towards the cost of their care. It seems inappropriate in today's economic climate to reduce these persons to non-contributing members of society.

A very good example of this situation is a 25 year old home TPN patient residing in the state of Washington with his wife and two children. Sixteen months ago this patient was declared disabled and began receiving a disability income from Social Security. Because he did not have health insurance, he applied for Medicaid benefits to cover the costs of his TPN. For many years, this man has had an interest in photography and related photographic equipment. It has always been his dream to have his own photographic equipment repair shop and recently he and a partner have taken steps towards making this dream a reality. His major concern with taking this step has been that of losing coverage for his medical care. If he opens his own shop, he will lose entitlement to Medicare because he will no longer be considered disabled. If he loses his Medicare benefits and begins making an income, his Medicaid coverage is jeopardized and the resulting financial burden on his family and business could be disastrous, forcing him back into his original position.

A second disincentive involves the lack of reimbursement for patient education and training. Before the home TPN candidate can be discharged from the hospital, he must be educated with reference to his particular illness and receive training with regards to the equipment and solutions he will be using in the home. The actual educational and training process is handled by a group of physicians, pharmacists, nurses and dieticians who together form a Clinical Management Team. Training and education of the patient can take as little as several days and as long as several weeks depending on the complexity of the system the patient must learn and the patients' ability to absorb this technical information. Because the training time varies, the estimated cost of such training can vary from \$300.00 to \$1,000.00 per patient.

Currently some hospitals are absorbing these costs in an effort to release TPN patients to their homes. Many hospitals however, are unable to absorb these costs and are thus unable to provide a training program for the possible home TPN candidate. Reimbursement for such a training program would encourage hospitals to move the TPN patient more quickly from the hospital to the home and thus, reduce current Medicare outlays to hospitals for the care of hospitalized TPN patients.

A third problem relates to the availability of reimbursable nursing care for the home patient. Often, when the TPN patient returns home, his physician has ordered regular skilled nursing visits. Medicare reimbursement for these services can only be made to certified home health care agencies. If the patient does not live in an area serviced by a certified agency or if he requires nursing services in excess of the two or three allowable visits per week, he must pay for these services himself. For example, a patient living in Utah might have difficulty locating a certified office which covers the area in which that patient is located. One of the major home health care agencies in the United States has informed Travenol Laboratories, Inc. that although they have an office in Utah, they are not certified and all their Medicare patients must pay their own bills for home nursing visits.

Additionally, the magnitude of red-tape and the dollars that must be spent to establish a Home Health Care agency to service just a region of the country prevents many from entering the market. Travenol Laboratories, Inc. provides many services to the patients' home and occasional nursing visits, as ordered by the physician, would provide for true continuity of care.

Finally there is a significant problem with reimbursement of TPN by state Medicaid programs. The provider of home TPN is often hindered in making services available to the patient because the patients' reimbursement is through the State's Medicaid program. Coverage of TPN and related professional services varies from state to state.

Several state programs will not reimburse out-of-state providers (Hawaii, Kansas). Many states require prior approval for home TPN, a process which requires tremendous paper work and professional involvement and takes many weeks to complete (Wisconsin, California, Colorado, Pennsylvania, Illinois, Minnesota, Maryland, Massachusetts, Missouri, Michigan). Two states will only reimburse the remaining 20% balance after Medicare (Arkansas, Virginia). Two states will only reimburse home

health care agencies (Tennessee, Idaho). Lastly, there are a few states that do not make reimbursement for Home TPN available at all. (Alabama, Arizona, Delaware, Florida, Georgia, Mississippi, North Carolina, West Virginia, Oklahoma, South Dakota, Wyoming). This is the worst case as the TPN patient is condemned to a life of institutionalization or death.

Travenol Laboratories, Inc. believes that the benefits of home care are obvious. The current system of reimbursement on both the part of Medicare and Medicaid place severe burdens both financially and emotionally on the potential home TPN patient.

If the overall goal is to reduce health care expenditures, then it would seem that the emphasis should be to establish reimbursement incentives designed to remove the chronically ill patient from the hospital where health care costs are the greatest and place these patients in the home where health care costs can be reduced without compromising patient care and safety.

NORTHWESTERN UNIVERSITY

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EVANSTON, ILLINOIS 60201

CENTER FOR HEALTH SERVICES
AND POLICY RESEARCH

TELEPHONE: 312-492-5641

November 6, 1981

Ronald F. Docksai, Ph.D.
Majority Health Director
Committee on Labor and Human Resources
United States Senate
Washington, D.C. 20510

Dear Mr. Docksai:

In response to your letter of September 1st, I am writing to provide comments on the testimony presented at the first day of hearings on Senate Bill 234, "The Community Home Health Services Act of 1981." As you know, we at the Center for Health Services and Policy Research have been working for the past four years on an evaluation study of the Five Hospital Homebound Elderly Program, a model long term home care program in the city of Chicago. The results of our study indicate that the type of socio-medical maintenance services which the Five Hospital Program provides can significantly reduce "old-old" elderly persons' risk of institutionalization and improve their quality of life, without increasing their mortality or use of acute hospital days. We are therefore pleased that the Hatch Bill, S.234, now proposes to expand services to this population at risk of institutionalization, which until now has been greatly underserved. We would like, however, to make the following points regarding the Bill as it is now written.

First, we are concerned about the skilled care requirement in the current Medicare home care reimbursement regulations. Although S.234 states that expanded services will be encouraged for persons at risk of institutionalization, it is not clear whether this wording will expand home care coverage to old-old individuals with long standing chronic diseases such as severe arthritis, old-strokes and amputations. These are persons in great need of, but currently ineligible for, Medicare reimbursed home care services. If the intent of the Bill is to encourage this coverage perhaps "regardless of presence or absence of a skilled care condition" should be added.

Secondly, we are concerned about the hospital-based bias of the Bill. Hospital-based home care has historically been the most expensive type of home care provided in the U.S., and there is no evidence in the scientific literature that the care is of higher quality than that provided by Visiting Nurse or Public Health nursing services at lower cost. While the Five Hospital Program is hospital-linked and includes physician services from the five participating hospitals, it is an independent community-based corporation which has no prior hospitalization requirement for acceptance of clients to service. The narrow emphasis on hospital-based care in the current language of the Bill could have the undesired consequence of denying reimbursement to programs such as the FHHEP, which ultimately may turn out to be more cost-effective than the hospital based model of care.

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Third, we would like to support the comments of others regarding the use of capitation as a reimbursement mechanism which may constrain overall costs for expanded home care. Finally, we would also like to suggest that this or some other Bill might like to authorize research on the role of private insurance for long term care as a method of reducing the public cost of this care. We would be happy to provide more details regarding this latter point, should you be interested in them.

In closing, let me repeat that we are pleased to know that Congress is aware of and concerned about the plight of the many chronically ill, old-old Americans, who have serious unmet needs for community-based health and social services. If we can be of any further assistance to you in your endeavors, please do not hesitate to write or call.

Sincerely yours,

Susan L. Hughes

Susan L. Hughes, DSW
Director
Program in Gerontological Health

SH:nm



TARKY LOMBARDI, JR.
50th DISTRICT
CHAIRMAN
COMMITTEE ON HEALTH

THE SENATE
STATE OF NEW YORK
ALBANY 12247

November 2, 1981

The Honorable Orrin G. Hatch, Chairman
U.S. Senate Committee on Labor and
Human Resources
Washington, D.C. 20510

Dear Senator Hatch:

Sincerest thanks for your kind letter of October 23. It is extremely rewarding to me to have our program presented at your forthcoming hearing on November 10.

I have asked the Director of our New York State Senate Health Committee, Mrs. Harriet Morse, to attend your November 10 hearing. She will introduce herself to you and will be available to respond to any questions which you or your staff might have. Mrs. Morse will be glad to meet with anyone you designate either before or after your hearing as well. She may be reached at (518) 455-3511.

In accordance with your request, we did forward a copy of our report to Congressman Guy Molinari who is an old acquaintance from New York State. We have also offered Guy any assistance or information he might need.

If we can be of any further service to you, please don't hesitate to contact us. We are extremely proud of our program and feel that it could be easily replicated on a national scale.

Kindest personal regards.

Cordially,

A handwritten signature in cursive script that reads "Tarky Lombardi Jr."

Tarky Lombardi, Jr.

TL/hm

NURSING HOME WITHOUT WALLS PROGRAMWHAT IT IS:

The Nursing Home Without Walls Program provides nursing home level care to disabled, chronically ill and invalid patients who are medically eligible for placement in a residential health care facility. Contrary to the usual practice of requiring a patient to conform to the programmatic mandates of providers of service, the Nursing Home Without Walls Program is tailored to the needs of each individual patient. Indeed, Nursing Home Without Walls' unique design can result in the savings of millions of health-care dollars, since it serves the same target population as institutions at about half the cost. At the same time, it allows for delivery of care in a home setting, where the patient is happier and more comfortable than in the institutional setting.

THE NAME:

The Program was named Nursing Home Without Walls since nursing home level services are provided in a non-institutional setting. It is not necessary for a patient to be in a nursing home in order to receive nursing home level services; hence the name, Nursing Home Without Walls.

HISTORY:

New York State Senate Health Committee Chairman, Tarky Lombardi, Jr. developed the initial Nursing Home Without Walls legislation in 1976; over the next two years, the concept was refined and was ultimately signed into law as Chapter 895 of the Laws of 1977. It became effective April 1, 1978. Among the factors that led Lombardi to seek this new approach to providing long-term health care were:

- * Public health reimbursement mechanisms were geared toward the support of institutional care. This resulted in patients being prematurely institutionalized and often maintained in an institution long after it was necessary, although the patient would have preferred to be at home;
 - * The increased average life expectancy of individuals and the increasing percent of New York's population age 65 and older. For example, the average life expectancy has increased from 45.6 for males and 49.3 females in 1900 to 69.9 for males and 76.9 for females in 1980, an increase of 53% and 56% respectively.
- B. L.

The percent of the total population age 65 and over has increased from 4.8% in 1900 to 11.7% in 1980.

- * The rapid rise in health care costs. National expenditures for nursing home care more than doubled between 1974 and 1978 according to the U.S. Government Accounting Office. In New York State, long-term institutional care consumes the largest percentage of public funds spent for health care. Medicaid pays for about 80% of the cost of long term care in New York, while Medicare pays approximately 3%. Private and other sources account for 17% of these payments between 1977 and 1981.
- * The occupancy rate for long-term institutional care in New York has exceeded 96 percent for several years. Thus it is often impossible to find a long-term care bed for a patient who could otherwise be discharged from an acute care facility.
- * Recent studies by the federal government have found that 20 to 40 percent of the nursing home population were inappropriately placed and could well be cared for at less intensive levels of care.

COMPONENTS OF THE LEGISLATION:

Patients:

- * The program must be offered to all Medicaid-eligible patients being considered for residential health care facility placement;
- * Private pay patients are eligible for the program;
- * Admission to the program is based on a comprehensive individual assessment of the patient's health, socio-psychological status and home environment. It is available to those patients who are medically eligible for a residential health care facility.

Budget:

- * Expenses for patients admitted to the program cannot be expected to exceed 75 percent of the local annual average Medicaid costs for maintaining the patient at a comparable level of care within an institution.

Providers:

- * Services to the patient are coordinated and managed by a single agency on a 24-hour, seven-day-a-week basis;
- * Providers must offer comprehensive services comparable to those offered by residential health care facilities.
- * Residential health care facilities, certified home health agencies, hospitals and local health departments may apply to become providers.

FINANCIAL SAVINGS:

The Nursing Home Without Walls Program has proven that residential health care facility services can be provided to patients in their homes at a cost considerably less than that in an institution.

A. Comparison to Skilled Nursing Facilities:

The Nursing Home Without Walls rate represents expenditures of less than 50 percent of the SNF rate -- saving over a quarter of a million dollars for 270 patients in November, 1980.

	<u>Average Monthly Costs</u> (November, 1980)
Patients in a Skilled Nursing Facility	\$ 1,955.72
Patients in Nursing Home Without Walls	<u>968.12</u>
Savings per Patient in Nursing Home Without Walls	\$ 987.60
X	X
SNF level patients served in November, 1980	270
=	=
Total Savings for 270 Patients	<u>\$266,651.00</u>

B. Comparison to Health-Related Facilities:

Nursing Home Without Walls patients are served at a cost of 69 percent of the cap and only 51 percent of the HRF rate, a savings of over \$116,000 for 194 patients in November, 1980.

	<u>Average Monthly Costs</u> (November, 1980)
Patients in a Health Related Facility	\$ 1,237.96
Patients in Nursing Home Without Walls	<u>636.92</u>
Savings per Patient in Nursing Home Without Walls	\$ 601.04
X	X
HRF level Patients served in November, 1980	194
=	=
Total Savings for 194 Patients	<u>\$116,601.00</u>

C. Comparison to Acute Hospital Care:

Many patients remain in hospital beds long after they actually require acute care because there are no available residential health care facility beds to which they can be discharged. The average cost for unnecessary hospital care in the counties which have Nursing Home Without Walls Programs was \$16,953 per patient. The November, 1980 Nursing Home Without Walls patients included 37.4% or 174 patients who were referred from hospitals. If they remained in an acute care facility for a similar period of time, the cost for this unnecessary care would have been $(174 \times \$16,953)$ \$2,949,822. The average Nursing Home Without Walls cost for the same period was $(174 \times \$1,865)$ \$324,510, a difference of \$2,625,312. This shows that the cost savings can be dramatic when discharge planning is done early.

PATIENT PROFILES:

* Average Age of Nursing Home Without Walls Patients:	73.8
(Ages range from 2 to 107)	
* <u>Patient Sex:</u>	
Female	76.3%
Male	23.7%
* <u>Source of Referral:</u>	
Hospitals	37.4%
Residential Health Care Facilities	1.9%
Community Agencies	52.5%
Family Members or Self	8.2%
* <u>Level of Care Upon Admission</u>	
Skilled Nursing Level	61.6%
Health Related Level	38.4%
* <u>Patient Living Arrangements</u>	
Live With Others (Family, Friends)	56.6%
Live Alone	43.4%
* <u>Discharge</u>	
To an Acute Care Facility	61.7%
To a Residential Health Care Facility	7.8%
Patient Improved	6.9%
Patient Died	10.2%
Other (Friends, Family)	13.4%

HOW IT WORKS:Certification Requirements for Providers:

- * Providers of services must be certified under Article 36 of the New York State Public Health Law. Detailed applications submitted to the State Department of Health describe plans for the program, including the geographic area to be served, the estimated number of visits to be provided and the expected staffing. The application is acted upon by the appropriate health systems agency and the State Hospital Review and Planning Council, with final approval by the Commissioner of Health.

- * Services regularly reimbursed by Medicaid include nursing, physical therapy, occupational therapy, speech pathology, home health aide, personal care visits, homemakers, housekeepers, medical supplies and medical equipment and appliances and must be provided under Nursing Home Without Walls.
- * Ten additional services may also be provided under the Nursing Home Without Walls program. These services are made available through a waiver from the Federal Government under which they have become Medicaid reimbursable. An example of a waived service is minor home improvements such as ramps and handrails. Respite service, home maintenance and nutritional counseling are also included among the waived services.

Selection of Patients:

- * To be eligible for Nursing Home Without Walls patients must be medically eligible for care in a residential health care facility; their home environment must be suitable; the patient and family must want the program. The annual cost of providing care at home must not be expected to exceed 75 percent of the local annual Medicaid average for the appropriate level of care.
- * The patient's health status and the appropriate level of care are determined by use of the DMS-1 Long Term Care Placement Form which scores the patient's physical and mental status and medical requirements. The assessment yields a score indicating the patient's required level of care. A patient residing in an area where the program is available who has been determined eligible for long term placement must be notified of the Nursing Home Without Walls program as an alternative to institutional care by the local department of social services.
- * A Home Assessment Abstract is used by the provider and the local department of social services to assess the appropriateness of the patient's home environment and types and frequency of services needed. The initial budget is based upon this information.
- * If the cost is expected to be within the 75 percent cap on an annual basis, the services may begin.

Patient Management:

- * When the patient enters the program the provider must assure total management and coordination of all patient services.
- * Local departments of social services share responsibility for Medicaid patients. Each patient is reassessed at least every 120 days.

PRESENT PROVIDERS:

The start-up of the program was deliberately slow and cautious to assure appropriate development. Since the nine initial providers approved in 1978 have demonstrated the success of the program the State is now encouraging its expansion. Today there are 19 programs approved in 13 counties. Additional applications are currently under consideration. Providers approved to date are:

Cattaraugus County Health Department	Cattaraugus County
Erie County Health Department	Erie County
24 Rhode Island Street Nursing Home	Erie County
Onondaga County Health Department	Onondaga County
Visiting Nurse Association of Central New York	Onondaga County
Metropolitan Jewish Geriatric Center	Kings County
Montefiore Hospital	Bronx County
St. Vincent's Hospital	New York County
Visiting Nurse Service of New York	Queens County
Eddy Geriatric Center	Rensselaer County
Rockland County Health Department	Rockland County
Jewish Home and Hospital for Aged	New York County
Visiting Nurse Association of Staten Island	Richmond County
Loretto Geriatric Center	Onondaga County
Chemung County Health Department	Chemung County
WK Nursing Home Company	Bronx County

St. Mary's Hospital

Kings County

Steuben County Home
Health Agency

Steuben County

Chautauqua County Health
Department

Chautauqua County

ENDORSEMENTS:

Letters from Nursing Home Without Walls patients and their families illustrate the effectiveness of the program and their satisfaction. Patients are pleased to remain in their own homes and live independently. Family members say they are alleviated of the burden of constant care for the patient, and their minds are eased since the patient receives excellent care. Health professionals attest to its cost-savings features and its patient-centered focus. Following are excerpts from some letters:

"... I want to tell you how happy we are with the results. In a week's time there is a vast improvement in my mother-in-law's physical and emotional condition. Her environment is more cheerful and she is looking cared for. I thank you for making her life a little better."

"Without the Nursing Home Without Walls program of your institution, there would have been no way for my parents to have been reunited, and to lead a comfortable life which is probably the exception for people of their age and physical ailment."

NATIONAL RECOGNITION:

The Nursing Home Without Walls program is receiving attention across the country. Several other states are attempting to replicate the program. It served as a model for Congressional legislation — the Medicaid Community Care Act of 1980 (Waxman-Pepper) and the proposed Title XXI addition to the Social Security Act (Packwood-Bradley). The concept of Nursing Home Without Walls was included in the Federal Omnibus Reconciliation Act of 1981. Abt Associates of Cambridge, Mass., is conducting a three-year evaluation of the program which began in September 1979 and is funded by the Health Care Financing Administration. The report is scheduled for completion in September 1982 and will serve as a basis for a nationwide program.

RECOMMENDATIONS:

In order to provide even greater benefits to New York State residents, several recommendations were made in the Lombardi report. They include:

- * The State should now encourage and expedite development of the Nursing Home Without Walls program, making the program available to every resident of the State who prefers to be cared for at home.
- * Ensuring that all who are in need of Nursing Home Without Walls services have access to the program regardless of payment source. The State should take definite steps to ensure awareness of the program and accessibility by all residents.
- * Amending federal regulations, so that responsible relatives may contribute toward care, over and above what is Medicaid reimbursable, without jeopardizing Medicaid eligibility.
- * When there is more than one potential Nursing Home Without Walls patient in a household, their budgets should be combined. Cases have been reported where two members of a household are assessed for the program but one must be excluded because the cost would exceed the cap, even though the other household member's cost would be below the 75 percent cap.
- * Encouraging the State Departments of Social Services and Health to develop a program for physicians and hospital discharge planners to make them aware of the Nursing Home Without Walls program and its benefits. Since the physicians and discharge planners are most frequently responsible for making referrals to the long-term care system, they should be fully informed of the program and its services.

The CHAIRMAN. With that, we will recess these hearings until further notice. Thank you all for coming.

[Whereupon, at 1:15 p.m., the subcommittee recessed, to reconvene at the call of the Chair.]